



Physician Guidelines for the Screening, Evaluation, and Management of Alzheimer's Disease and Related Dementias

Created By
THE ALZHEIMER'S PROJECT
CLINICAL ROUNDTABLE
June 2021
Third Edition



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Acknowledgments

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approximately 100,000 individuals living with Alzheimer's and related dementias and is the number three cause of death in our County.

The Clinical Roundtable would not have been able to accomplish the development and adoption of countywide standards of care without the dedication of many clinical practitioners and care community members affiliated with various health systems in San Diego County. We would like to thank the leadership of our respective organizations for their support as we have diverted time and energy to this effort.

— Michael Lobatz, MD
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Background of The Alzheimer's Project

The Alzheimer's Project is a regional initiative established by the San Diego County Board of Supervisors to address the toll of Alzheimer's and related dementias on families, communities and our healthcare systems. The Clinical Roundtable is one of four groups to address these issues. The Clinical Roundtable brought together neurologists, geriatricians, geriatric psychiatrists, and geriatric psychologists in 2014 to begin to assess current clinical practices, and develop best practices standards for primary care physicians, internists, psychiatrists, nurse practitioners, and physician assistants caring for older adults in their practices. The Clinical Roundtable has continued to meet regularly over the past six years to provide ongoing review of new information, updates to the Guidelines, and resources for clinical practitioners. This is the third edition (June 2021) of the Clinical Guidelines.

Focus of the Clinical Roundtable

- Development of standards for screening, evaluation and diagnosis of Alzheimer's disease and related dementias.
- Development of guidelines for the management of long-term care and the behavioral and psychological symptoms and issues experienced by those afflicted.
- Education of primary care practitioners and their staff on standards and guidelines leading to countywide achievement of best practices.
- Identification of resources for physicians and their staff to inform family caregivers.
- Dissemination of tools for effective communication with patients and their caregivers.

The tools presented have been created to assist primary care physicians for identifying and managing patients with memory loss and dementia, as well as family members and caregivers affected by this disease. Primary care physicians practicing internal and family medicine significantly outnumber specialists including neurologists, geriatricians and psychiatrists combined. Therefore, as the incidence and prevalence for memory disorders continue to rise to unprecedented levels, it is inevitable that screening, evaluation, diagnosis, and treatment of many patients with Alzheimer's disease and related disorders will be managed by primary care physicians.

The Clinical Roundtable encourages the use of these tools to facilitate a more uniform approach among San Diego healthcare providers based on clinical standards of practice to improve patient care and outcomes. The goal is to determine clinical standards of practice to improve patient care and outcomes.

Many of the patients living with dementia can be effectively managed by primary care providers. These tools and additional training are offered to increase

the capacity of primary care providers in that regard. However, when the clinical presentation suggests a condition other than uncomplicated Alzheimer's disease or if the presentation of a particular patient is concerning to the practitioner, referral to a specialist is recommended.

These guidelines are intended to be a living document that will change as advances are made in the field. It is planned that the Clinical Roundtable will convene for periodic review of research literature and assessment of practice in the community to update these guidelines. Further, practitioners will be asked for their feedback on the algorithms, specific screening and evaluation instruments, and their impression of the impact on their increased capacity due to use the guidelines.

The algorithms were created after review of practices throughout the country, and all instruments recommended in these Guidelines were selected based on a thorough review of research literature, consideration of workflow of practices across San Diego County, and access to resources.

Background

Cognitive impairment and dementia are under-diagnosed in older individuals. This can lead to safety and health consequences, and also delays adequate evaluation and potential treatment. In addition to supporting a diagnosis of cognitive impairment, screening and evaluation of cognition may identify reversible conditions contributing to cognitive changes, or may help to reassure someone with cognitive concerns whose cognition in fact is normal.

The terms dementia, MCI, Major Neurocognitive Impairment and Mild Neurocognitive Impairment are defined here with some interchangeability. The current DSM-5 terminology is not uniformly used.

Dementia is an acquired decline in memory and/or other areas of cognition or behavior, of sufficient magnitude to cause impairment of social or occupational functioning.

DSM-5 has developed the term Major Neurocognitive Decline (MNCN), used with a variety of billing codes to describe dementia and related conditions. Major Neurocognitive Disorder (Dementia) as defined by the DSM-5 includes:

- Cognitive deficits in one or more areas of cognition, such as memory, language, visuospatial abilities, (apraxia, aphasia, agnosia), or executive function)
- Cognitive defects must impair social or occupational functioning
- Gradual onset and progressive cognitive decline
- Not due to other CNS cause of dementia, substance abuse, or systemic conditions that can cause dementia
- Not due to delirium
- Not accounted for by another Axis 1 disorder

Mild Cognitive Impairment (MCI), or Mild Neurocognitive Disorder, is defined as a change in cognitive abilities, noticed by the patient, family member or close friends, or the MD, in which there is cognitive impairment in one or more domains (memory,

attention, executive function, language, visuospatial abilities) with minimal impairment of instrumental activities of daily living (IADL). Although there is no absolute dividing line between MCI and mild dementia, the degree of impairment is used to make the judgment. Someone with MCI can compensate for many of their cognitive problems and can remain independent in many complex activities, sometimes with mild adjustments.

Mild Cognitive Impairment (MCI), or Mild Neurocognitive Disorder, is marked by focal or multifocal cognitive impairment with minimal impairment of instrumental activities of daily living (IADL) that does not cross the threshold for a dementia diagnosis. MCI can be the first cognitive expression of Alzheimer disease (AD), or may be secondary to other disease processes (i.e., other neurologic, neurodegenerative, systemic, or psychiatric disorders) that can cause cognitive deficits. MCI does not necessarily progress, and depending on the underlying cause(s), it can improve. Caveat: brief screening tests such as the MiniCog are less sensitive for detection of MCI than for dementia.

The brain and cognitive abilities change with aging. For example, difficulty retrieving names or words, lapses of attention ('why did I go into that room,' 'what was I saying,' etc), and slight slowing of cognition are signs of normal brain aging. These should be differentiated from serious cognitive changes.

Starting the Conversation

When to Begin Discussion of Cognition in an Older Adult:

- Annual Wellness Visit,
- Warning Signs expressed by patient and/or family member,
- Patient who forgets appointments or is noncompliant with medications,
- Upon observation by a healthcare professional during a scheduled office visit.

Annual Wellness Visit

Medicare beneficiaries are eligible for an Annual Wellness Visit (AWV), which is separate from the Initial Preventive Physical Examination or other routine physical checkups. The prescribed components of an AWV includes a review of the beneficiary's potential risk factor for depression, using an appropriate screen such as the PHQ-2 or PHQ-9, as well as a check for cognitive impairment, as follows:

"Detect any cognitive impairment the beneficiary may have: Assess the beneficiary's cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others."

The Annual Wellness Visit includes a Health Risk Assessment (HRA), and physician discretion will guide the implementation and use of the HRA questionnaire. Each insurance payer may specify their own HRA questionnaire. While Medicare does not identify or prescribe a particular cognitive screening test, many practitioners use the Mini-Cog test.

Screening prompted by other concerns

Family members may notice changes in cognition or function before patients do. People with MCI or mild dementia may retain some awareness of their decline in abilities, but as memory loss worsens, denial or unawareness that there is a problem (anosognosia) becomes increasingly common.

A physician or their office staff may notice problems, for example, patients missing appointments, calling for refills of medications erratically, or having difficulty giving a completely coherent history.

When the practitioner detects any cognitive impairment in either an AWV, a routine physical checkup, or other appointment, he/she may find it an appropriate opportunity to either begin a discussion, or suggest a follow-up appointment to discuss concerns of the patient, family member or physician. A thorough history with care on cognitive function will be helpful.

During an appointment with only the patient in attendance, the patient may be unaware of or deny symptoms of memory loss. It is therefore important to obtain collateral history from family or close friends. The AD8 is often used as an initial screening instrument with the individual experiencing memory loss, but it is preferred to be completed by someone who has been observing the patient regularly.

Having the Conversation

Recommended initial questions to ask older patients regarding their concerns about their memory or cognition are:

- Are you worried about your memory?
- Have you noticed a change in your memory that concerns you?
- During the past few months, have you had any increasing problems with your memory?

It is important to focus on change in function or abilities over the past six months to two years.

The Gerontological Society of America's KAER Toolkit suggests, "By raising this topic, PCPs will communicate to their older adult patients that brain health and changes in memory and cognition that may occur in aging are important aspects of their overall health. Raising the topic will also help to normalize attention to cognition in primary care and encourage older adults to be aware of changes in their cognition and to tell their PCP about cognition-related concerns, if any. Many older adults are reluctant to express such concerns to their PCP, in part because of fear and stigma often associated with dementia. A frank yet sensitive introduction to the topic by the PCP is a highly appropriate first step to kickstart the cognition conversation. This approach can open the way for older adults to reveal any cognition-related concerns they may have."

The K in KAER stands for Kick Starting the conversation about cognitive impairment. This may include questions about cognition-related function, such as difficulty paying bills or directions to a familiar place.

Practitioners can refer to the 10 Warning Signs to direct the conversation. Tools, including short videos on suggested interactions, are available on the website, <https://championsforhealth.org/alzheimers>.

Listening and acknowledging concerns of a patient's **family member or caregiver** is usually most informative, as the individuals with cognitive decline often does not recognize their deficits. The use of an informant survey such as the AD8 or IQCODE is very helpful as part of the follow-up appointment. Family members can be handed the survey at check-out, and asked to complete it prior to the next, more comprehensive visit. By completing the survey outside of the medical office, the family member has more time to recall specific concerns, and can provide this valuable information to the provider without disclosing too much in front of their loved one.

Some key messages to impart to older adults include:

- The brain ages, just like other parts of the body.
- Cognitive aging is not a disease, and is not the same as Alzheimer's disease or other dementia. It is a natural, lifelong process that occurs for everyone, and is different for each person.
- Some cognitive functions improve with age.
- There are steps individuals can do that may promote and support their cognitive health.

Individuals concerned about their memory may be among the "Worried Well" and need reassurance that their experience is part of normal aging. Tracking concerns over time will help the practitioner to determine when to assess or reassess cognitive function.

An algorithm for screening

An algorithm for screening was created by clinicians with expertise in Neurology, Geriatric Medicine, Geriatric Psychiatry, Psychiatry and Geriatric Psychology representing different San Diego health care systems. The members reviewed guidelines and studies of different screening tests and questionnaires, as well as screening algorithms proposed by organizations across the country, including major universities and the Alzheimer's Association.

The goal was to develop an algorithm of when screening should be considered, and what brief instruments have reasonable evidence for use. Additional goals were to define a brief workup and focused management that should follow a positive screen, and to determine whether there are potentially treatable factors that should be addressed before undertaking or referring the patient for a more detailed evaluation.

Intended use

Primary care physicians, internists, psychiatrists, nurse practitioners, and physician assistants caring for older adults in their practices, as well as psychiatrists and geriatric psychiatrists can use the algorithm to carry out a focused screening. The intended use is in older patients where there is suspicion of cognitive decline. This type of screening could potentially be used in other settings, for example in an Emergency Room or preoperatively to rule out other conditions presenting as disorientation or dementia. Other medical assistants (MA, CNA) in the practice can assist the screening by conducting portions of the algorithm, including the MiniCog and collecting informant information while rooming the patient.

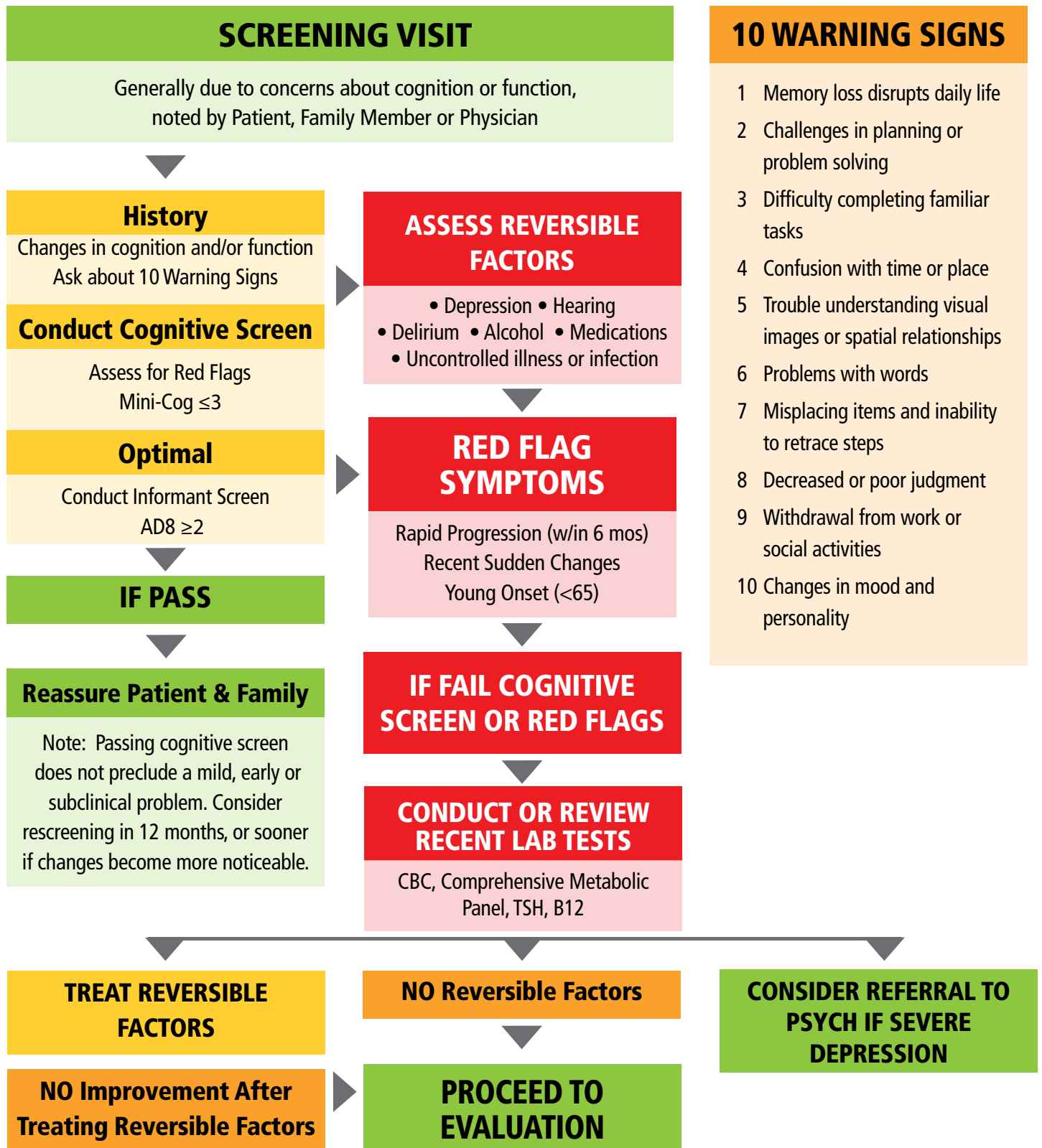
Efficacy

The screening instruments selected are the MiniCog, a brief direct test of cognition; and the AD8, a questionnaire for an informant. These may be used separately or together. Studies suggest that a combination of direct cognitive testing and informant

Alzheimer's Clinical Roundtable

Recommended Screening Algorithm for Adult Cognitive Impairment

NOTE: Cognitive screening may be a part of a regular annual physical exam.



10 WARNING SIGNS

- 1 Memory loss disrupts daily life
- 2 Challenges in planning or problem solving
- 3 Difficulty completing familiar tasks
- 4 Confusion with time or place
- 5 Trouble understanding visual images or spatial relationships
- 6 Problems with words
- 7 Misplacing items and inability to retrace steps
- 8 Decreased or poor judgment
- 9 Withdrawal from work or social activities
- 10 Changes in mood and personality

assessment is more accurate in detecting cognitive decline than either one alone.

Studies of the MiniCog suggest that it has sensitivity of over 80% and specificity ranging from 60 – 80% to detect dementia. Studies of the AD8 suggest that it has sensitivity and specificity that both exceed 80% to detect dementia. These results compare favorably with other widely used tests such as the Mini-Mental State Examination (MMSE).

Mild cognitive impairment (MCI) or mild neurocognitive disorder (MNCD) refers to a lesser degree of cognitive decline than dementia. These conditions may be caused by many different factors. Brief screening tests or questionnaires are less sensitive for MCI or MNCD than for dementia.

How to utilize the tool

An algorithm for cognitive screening indicates the types of symptoms that may trigger a screen, and the process of using the MiniCog and/or AD8. The MiniCog and AD8 instruments and scoring keys are included in this document, and are available online.

Scoring cut-offs for these instruments are listed. If a screen is positive, medical factors, depressive symptoms and a brief panel of laboratory tests should be considered to determine if there may be treatable factors. Hearing and vision should also be considered as factors to address.

If a screen is negative, there is a decreased chance that dementia is present but does not rule out MCI. The clinician may decide to pursue a more detailed evaluation anyway, for example if there are issues such as decisions about driving, work or finances. If the screen is negative, the clinician may decide to rescreen the patient during follow-up at six months or one year.

Several RED FLAG symptoms or features are listed, as examples of situations where a more detailed evaluation should be considered, regardless of the results of the screening. A positive screen, with or without an attempt to determine and correct reversible factors, should lead to an evaluation.

Vitamin level testing

- With exception of vitamin B12 deficiency, there is no convincing evidence for vitamin deficiency causing dementia.
- However, patients with suspected dementia are at risk for nutritional disorders. When there is concern in that regard, checking vitamin levels as appropriate for general health maintenance may be considered.
- Additionally, patients sometimes self-treat with over-the-counter products. Frequently, the ingredients for such products are high doses of vitamins. As such, checking vitamin levels when appropriate to rule out vitamin toxicity may be considered.

Recommended Screening Instruments

Mini-Cog

http://www.alz.org/documents_custom/minicog.pdf
Spanish: <http://mini-cog.com/wp-content/uploads/2015/12/Mini-Cog-Spanish.pdf>

Normal range: ≥ 4

Informant/Family Questionnaire

AD8 http://www.alz.org/documents_custom/ad8.pdf
Normal Range: 0 - 1

Patient Health Questionnaire for Depression (PHQ-9)

(source) http://www.cqaimh.org/pdf/tool_phq9.pdf
PHQ-2 are the first two questions of the PHQ-9 (see page 51)

Optional: Geriatric Depression Scale

http://geriatrictoolkit.missouri.edu/cog/GDS_SHORT_FORM.PDF

Reproducible copies are included in the back of this booklet.

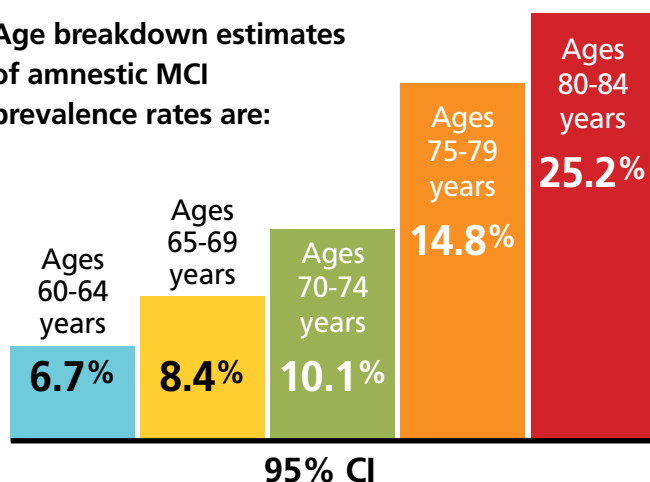
Mild Cognitive Impairment

Mild Cognitive Impairment (MCI) is characterized by one or more areas of cognitive impairment (most commonly memory and executive function) with minimal impairment of instrumental activities of daily living (IADL) that does not cross the threshold for a dementia diagnosis. MCI can be the first cognitive expression of Alzheimer disease (AD), or may be secondary to other disease processes (i.e., other neurologic, vascular, neurodegenerative, systemic, or psychiatric disorders) that can cause cognitive deficits. While MCI can lead to major neurocognitive disorders in the future, it can also stay stable in its presentation, or it can improve.

Mild Neurocognitive Disorder is a term developed by DSM-5 that overlaps with the description of MCI. There are different kinds of MCI. The following information is excerpted from a consensus statement by the American Academy of Neurology regarding MCI:

“Amnestic MCI (aMCI) is a syndrome in which memory dysfunction predominates; Nonamnestic MCI refers to impairment primarily in other cognitive domains (e.g., language, visuospatial, executive). The “narrow” definition of MCI includes amnestic, and the “broader” definition also includes nonamnestic MCI. The general prevalence rate for narrow criteria varied from 3.2% to 25% of individuals 65 years of age and older across studies conducted. The prevalence rate for the broader criteria varied between 13.4% and 42%.

Age breakdown estimates of amnestic MCI prevalence rates are:



Persons with MCI are at higher risk of progressing to dementia than age-matched controls (high confidence, multiple concordant Class I studies, meta-analysis). But it is important to acknowledge that MCI does not necessarily lead to Alzheimer's disease or related dementia. In individuals with MCI older than age 65 years followed for two years, the cumulative incidence for the development of dementia is 14.9%. Persons diagnosed with MCI may remain stable, return to neurologically intact, or progress to dementia (multiple Class I studies, 14.4%–55.6% reverting to normal).

Assessing MCI

Clinicians should consider MCI and not assume that reported cognitive concerns are related to normal aging. Family members often provide important collateral history, e.g., regarding the patient sometimes forgetting information, having trouble in new and unfamiliar situations, having trouble with more complex aspects of work, managing money, driving, using a cellphone or a computer.

Clinicians should not rely on a history of subjective memory concerns alone, and should use validated assessment tools as recommended in the screening section, including identification of reversible conditions or factors. For patients who perform at a borderline on screening, suggesting MCI, clinicians should perform a more formal clinical assessment, with tools such as the MMSE, MoCA, qMCI, or SLUMS, and assess for the presence of functional impairment related to cognition.

Going beyond office-based assessment, formal neuropsychological testing can be extremely helpful to sensitively assess cognition. Serial assessments over time can also help monitor for changes in cognitive status.

The laboratory workup for MCI is similar to that of dementia. Brain imaging is not essential in all cases of MCI, but MRI can help to show vascular brain changes (e.g., significant white matter disease and lacunes or large-vessel infarction) or subtle atrophy patterns in cases of neurodegeneration.

Pharmacologic treatments for patients diagnosed with MCI

A number of studies have concluded that the use of cholinesterase inhibitors, memantine, vitamins, and other supplements were proven not to be effective for individuals with MCI. Further, the use of cholinesterase inhibitors and memantine are not FDA approved for MCI, and would be off-label prescriptions. There are a number of studies to support this finding on the American Academy of Neurology (<https://aan.com>).

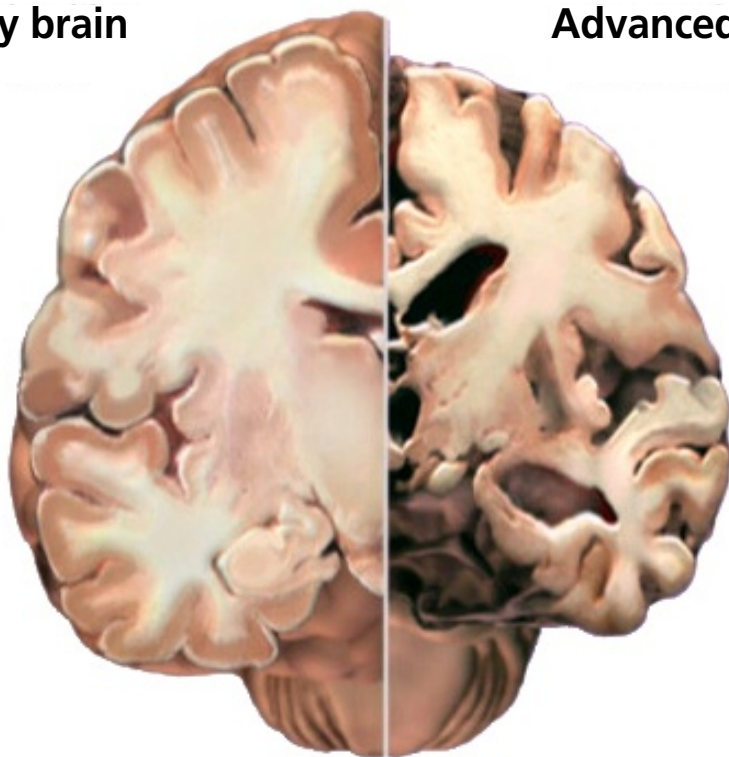
Nonpharmacologic treatments effective for patients diagnosed with MCI

Studies have shown that for patients with MCI, treatment with exercise training for six months is likely to improve cognitive measures (moderate confidence in the evidence based on 2 Class II studies). Individuals with MCI are encouraged to practice the same behaviors as individuals without MCI; eat a healthy diet, stop smoking, use alcohol in moderation, remain physically active, challenge their brain on a regular basis and maintain, and possibly expand, social connections.

Interested patients may be directed to clinical research focused on long-term brain health, biomarker research, or other clinical trials to assess their condition over time. The participation of individuals with MCI in clinical research is crucial to finding effective treatments for dementia.

Healthy brain

Advanced Alzheimer's



Evaluation of Cognitive Decline and Dementia

Background

Alzheimer's disease (AD) is the most common cause of dementia in older individuals. Other common causes are vascular cognitive impairment, Dementia with Lewy Bodies (DLB), Frontotemporal Lobar Degeneration (FTLD) and later stage Parkinson's disease. Many other conditions may cause or contribute to dementia, including medically treatable conditions. In many patients with dementia, more than one pathology contributes, e.g., Alzheimer's accompanied by vascular changes.

Evaluation is more detailed and time-consuming than screening. The clinician performing an evaluation should have a thorough knowledge of diagnoses of cognitive disorders such as Alzheimer's disease and other types of dementia, and should also be comfortable disclosing a diagnosis of Alzheimer's disease or other dementia to patient and family.

There are many guidelines for the evaluation of dementia. Recent guidelines for Alzheimer's disease, Mild Cognitive Impairment (MCI) due to AD, as well as prodromal AD emphasize biomarkers for amyloid and neurodegeneration in addition to clinical evaluation. These biomarkers can increase accuracy of diagnosis beyond clinical evaluation alone, and may be necessary to determine appropriate treatment options.

Diagnostic criteria also exist for vascular dementia, DLB, FTLD, and other disorders.

An accurate diagnosis of cognitive impairment, dementia and its etiology can help to guide the patient and family regarding planning, accessing family and community resources, and appropriate use of symptomatic treatment.

Benefits of Assessing for MCI or Dementia

- Assist with planning for the future
- Identify treatable or reversible factors (e.g., vascular risk, sleep, medications) and lifestyle interventions (e.g., physical activity, diet)
- Opportunities for early therapy or clinical trials

An algorithm for diagnostic evaluation

An algorithm for diagnostic evaluation was created by a group of clinicians with expertise in Neurology, Geriatric Medicine and Psychiatry, representing different San Diego health care systems. The members reviewed guidelines and studies of evaluation, as well as published diagnostic criteria. The goal was to develop an outline of the elements of evaluation of dementia or cognitive loss, to help to guide clinicians and improve the quality of care.

Who should carry out an evaluation?

Physicians, Physician Assistants, Nurse Practitioners, or a clinical team member with adequate training can use the algorithm to carry out an evaluation.

The clinician or team member should have a strong knowledge base concerning cognition, aging and different types of dementia, and also experience in how to disclose the diagnosis, develop a management plan, and make appropriate use of community resources.

For patients with unusual or uncommon disorders, referral to a subspecialty dementia clinic or practitioner is advisable. Unusual clinical pictures, including progressive aphasia, progressive visual-perceptual impairment, apraxia, early movement disorder features, young onset of cognitive impairment (before age 65), rapidly progressive dementia, or presence of a strong family history of dementia are often best evaluated by a subspecialty clinic.

The evaluation process

An evaluation typically will consist of at least one detailed visit to obtain the necessary elements of history, examination, cognitive assessment, and to determine appropriate laboratory testing, neuroimaging and other consultation or tests as appropriate.

1. Obtaining collateral history from an informant to document cognitive, functional and behavioral symptoms is strongly recommended whenever possible.

2. Discussion of the results of the evaluation, disclosure of the likely diagnosis, the prognosis, and an outline of treatment options, sources of information and resources is best left for a second visit.
3. Discussion of safety concerns including kitchen appliances, home safety, medications, finances (to avoid elder abuse scams), firearms and other weapons, and driving. Driving is the only safety issue where there is a legal requirement of the provider to report to another agency; in this case the DMV for their review and potential testing.
4. Referrals and additional testing as a result of the evaluation require specific clinical expertise. They may include:
 - Psychiatric assessment.
 - Neuropsychological testing.
 - Additional medical evaluation.
 - Genetic counseling.
 - Neuroimaging testing, e.g., MRI or CT.

Biomarker Testing

Biomarkers can detect the presence of amyloid brain pathology (amyloid PET or CSF A-beta42, tau aggregation and pathology (Tau PET or CSF P-tau181) or neurodegeneration (FDG PET detects regional patterns of impaired glucose metabolism, CSF total tau reflects neurodegeneration). Some of these tests, e.g., amyloid and tau PET, are FDA approved but not covered by insurance. CSF biomarker tests may be performed by CLIA-approved laboratories, but the tests themselves have not received FDA approval and are not reimbursed. FDG PET is reimbursed only for distinguishing between AD and FTD in people with MediCare (i.e., older than 65).

There are several emerging biomarker tests:

Plasma levels of A-beta42/40 can predict amyloid PET results. Plasma levels of several forms of Phospho-tau (e.g., P-tau181, 217 and 231) have high sensitivity and specificity for AD, even at the stage of MCI.

At present, we recommend that these biomarker tests are best left to subspecialty clinics and providers.

Genetic testing

Genetic variants in the Apolipoprotein E (APOE) gene, called APOE e2, 3 and 4, affect the risk of developing late onset Alzheimer's Disease. People with 1 copy of APOE e4 have a 2-3 fold higher lifetime risk of Alzheimer's than carriers of the e3/e3 genotype. People with 2 copies of e4 have a 6-10 fold higher lifetime risk of developing Alzheimer's. **We do not recommend APOE gene testing as part of a diagnostic workup because the results do not clearly point towards or against a diagnosis.** People sometimes have APOE tested through 23andme or direct to consumer companies, or as part of cardiovascular panel tests. There are resources for patients to review should they consider obtaining APOE testing. (See RESOURCES)

Rare families with autosomal dominant Alzheimer's with multiple affected family members and very early age at onset (30-50 years) may have gene mutations in APP, PSEN1 or PSEN2. **Testing for those should be preceded by genetic counseling and a specific disclosure process.**

When to evaluate

The decision to evaluate could follow a screening assessment. In some situations, for example concerns about mild cognitive impairment, or cognitive problems that could affect work, driving or finances, an evaluation is appropriate.

Efficacy

Clinical guidelines and criteria for Alzheimer's disease (AD) have high sensitivity, in excess of 80-90%, but lower specificity – i.e., they may sometimes misdiagnose AD when other etiologies are present.

Biomarkers such as amyloid testing in CSF or amyloid imaging have high specificity, i.e., if they are negative, AD is highly unlikely.

Clinical criteria for other disorders have been less thoroughly evaluated and were mainly assessed in tertiary referral settings. Sensitivity greater than 80% has been noted for FTD and 70-80% for DLB. Vascular cognitive impairment (VCI) often accompanies AD, and **many people with late life dementia show mixed pathology**. Vascular risk factors and CT or MRI imaging help to evaluate the likelihood of VCI.

Advantages of MRI for Dementia Diagnosis

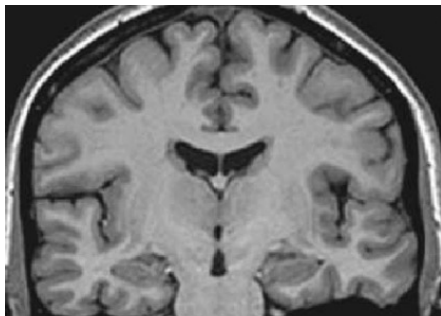
- Can show overall and regional brain atrophy
- Highly sensitive for vascular pathology
- Can show other lesions
- Contrast typically not needed

MRI vs CT for Dementia

Guidelines for the evaluation of dementia emphasize neuroimaging but do not specify head CT vs MRI. Head CT and MRI are comparable for ruling out disorders such as subdural hematoma and certain types of CNS tumors that are unusual causes of dementia. CT can also show rarefaction of white matter consistent with subcortical white matter disease due to CNS ischemia.

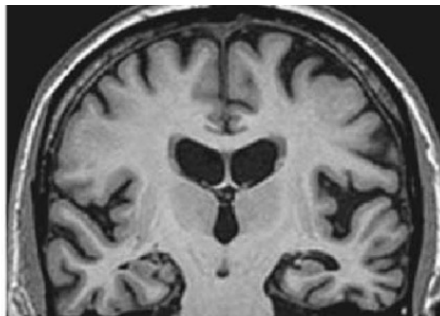
However MRI is superior for demonstrating regional brain atrophy (e.g., in the hippocampus or parietal association cortex), which are suggestive of Alzheimer's. MRI can be combined with quantitative assessment of brain volumes to try to identify regional atrophy more precisely. MRI also can assess the CNS effects of vascular risk much more accurately, e.g., by evaluating white matter hyperintensities, lacunes and micro-hemorrhage. For Normal Pressure Hydrocephalus, certain classic measures can be done either on CT or MRI but are more precise on MRI, and additional signs can be detected.

Brain MRI in dementia

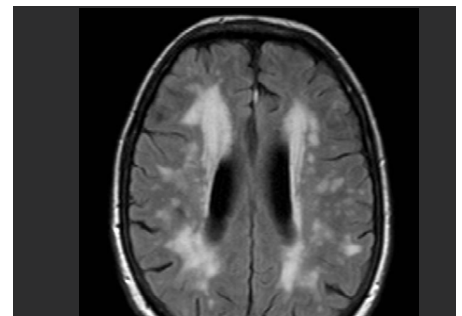


Healthy

Volume loss in the hippocampus and temporal lobe, decreased cortical thickness, and enlargement of ventricles occur in Alzheimer's



Alzheimer's Disease



Vascular Dementia

White matter hyperintensities on T2 sequences

PATIENT REFERRED FOR EVALUATION OF ADULT COGNITIVE IMPAIRMENT

BASED ON RESULTS OF SCREENING PROTOCOL

Evaluation to be conducted by PCP/Neurologist/Psychiatrist as appropriate

DIAGNOSTIC WORKUP

Detailed History: Informant Interview (IQCODE, QDRS, AD8), Cognition, Function and/or Behavior Changes

Neurological exam

Mental Status Test: MoCA*, qMCI, MMSE*, or SLUMS *requires remuneration

Depression Screening: Geriatric Depression Scale 7 Item (≥ 8)
PHQ-9 and/or Structured Questions

IF MOCA OR SLUMS NORMAL

Reassure patient.
Consider rescreening 3-6 months

If concern re MCI consider
Neuro-psychological testing

If Persistent Depression

Refer to psychiatrist, other specialists
or treat as appropriate

IF FAIL EVALUATION INSTRUMENT Proceed to Labs & Imaging

- 1 **Labs:** Comprehensive metabolic panel if not already done at screening, or others as appropriate
- 2 **Imaging study:** MRI (preferred) or CT
- 3 **Neuropsychological testing**
(optional - consider for atypical or mild or early onset cases)

DIAGNOSIS

TYPICAL DEMENTIA SYNDROME

Probable Alzheimer's Disease w/ or w/out cerebral vascular co-morbidity

- 1 Discuss & disclose; counsel patient and family
- 2 Develop Treatment/Management Plan
- 3 Access/provide community resources

ATYPICAL CASES

Parkinsonian features, hallucinations, prominent aphasia, early onset, rapid progression, fluctuations, unexplained visual impairment, severe depression

Referral to neurologist, psychiatrist, or geriatrician recommended

Evaluation of Cognitive Decline and Dementia

Recommended Evaluation Instruments

Informant surveys

Informant surveys may be sent out to caregivers prior to the evaluation appointment. Reproducible copies are included in the back of this booklet.

Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

(source) <https://www.alz.org/media/documents/short-form-informant-questionnaire-decline.pdf>

<https://rsph.anu.edu.au/research/tools-resources/informant-questionnaire-cognitive-decline-elderly>

Quick Dementia Rating Survey (QDRS)

<https://alz-journals.onlinelibrary.wiley.com/doi/10.1016/j.dadm.2015.03.003>

Patient Evaluation Instruments

Some of these instruments require remuneration to the copyright holder. The clinician is advised to become knowledgeable and comfortable with one of these, and to use it consistently with patients.

The Montreal Cognitive Assessment (MOCA)

Public domain: www.mocatest.org/

Normal Range: 26 – 30, for people with < HS education, add 1 point to the total score

The MOCA is a cognitive test that briefly assesses executive/visuospatial function, memory, language, attention, calculation and orientation. Cut-off scores have been developed and it has been tested in the diagnosis of AD, DLB and PD-related disorders. Translated versions are available, in many languages, and there are 3 alternative versions in English.

Although the MOCA may be used as a stand-alone test, and has relatively high sensitivity for the diagnosis of dementia, it is less sensitive for MCI or mild dementia. In that setting, additional testing, either office-based if the clinician has appropriate knowledge or skills, or by a neuropsychologist, is strongly recommended.

Use of the MoCA currently requires registration at a website, viewing of instructions about how to administer the MoCA and payment of a fee to the copyright holders. MoCA also has a telehealth instrument available.

Quick Mild Cognitive Impairment (qMCI)

Public domain: <http://www.qmci.ie>

Identifying mild cognitive impairment (MCI) is challenging. The qMCI was developed as an efficient screening test for MCI with sufficient sensitivity and specificity for use in busy clinical practice. The Qmci was shown more accurate than the ABCS 135, 6CIT, GPCOG, SMMSE and had similar sensitivity but greater specificity than the MoCA in differentiating MCI from normal.

St. Louis University Mental Status (SLUMS)

Public domain: <https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/assessment-tools/mental-status-exam.php>

Normal Range: 27 – 30; MCI: 21 – 26; Dementia: 1 - 20

30-point questionnaire that tests for orientation, memory, attention and executive function. Better at detecting mild neurocognitive disorder than MMSE.

The Mini-Mental State Exam (MMSE)

The Mini-Mental State Exam (MMSE) was originally developed as a general cognitive screening test. Since 2000, it has been licensed through Psychological Assessment Resources (PAR). There are a number of other instruments on their website as well, including the DRS-2, OACS, BPAD, and Cognistat 5.

<https://www.parinc.com/SearchResults?Search=dementia>

Cutoff scores on these instruments should be treated cautiously - beyond simply looking at the total score, it is often helpful to review the areas where a patient loses points to try to identify a cognitive profile (e.g., Impairment of memory and orientation would point to an amnesic disorder)

Evaluation of Cognitive Decline and Dementia

Other cognitive instruments:

Rowland Universal Dementia Assessment Scale (RUDAS)

The **RUDAS** was developed for assessment that consider people with lower levels of literacy.

Public domain: <https://www.dementia.org.au/resources/rowland-universal-dementia-assessment-scale-rudas>

Measure/Assess IADLs

The Functional Activities Questionnaire (FAQ) is a validated instrument that assesses level of performance of 10 different complex (Instrumental) activities of daily living. It should be given as an Informant questionnaire.

<https://www.alz.org/careplanning/downloads/functional-activities-questionnaire.pdf>

<http://consultgeri.org/try-this/dementia/issue-d13.pdf>

Definitions of Specific Cognitive Impairment Types

As detailed earlier, the latest DSM-5 manual uses the term “Major Neurocognitive Disorder” for dementia and “Mild Neurocognitive Disorder” for mild cognitive impairment. This Guidelines booklet on Alzheimer’s resources uses the more familiar terminology, as the new terms have yet to be universally adopted.

Mild Cognitive Impairment

Mild deficit in one (single domain) or more than one (multi-domain) cognitive domains: memory, executive function, visuospatial, language, attention. Intact instrumental ADLs (IADLs) and basic ADLs does not meet criteria for dementia.

Alzheimer’s Disease

Most common type of dementia (60–80% of cases).

Gradual onset and progression of memory loss, disorientation, impaired judgment/problem solving, and language. Behavioral changes may include apathy/depression, and delusions. Social skills are typically preserved.

Dementia with Lewy Body Disease or Parkinson’s Dementia

Second most common type of neurodegenerative dementia (up to 20% of cases)

Hallmark symptoms include visual hallucinations, REM sleep disorder, parkinsonism, and significant fluctuations in cognition

Fronto-Temporal Dementia

Third most common type of neurodegenerative dementia primarily affecting individuals in their 50s and 60s. Defined by EITHER marked changes in behavior/personality OR language variant (difficulty with speech production or loss of understanding of word meaning, which typifies the language variant. More recently, the term Fronto-temporal Lobar Degeneration has been used to include behavioral variant FTD, Progressive Aphasia, and movement disorders with a prominent cognitive component, namely Corticobasal Syndrome (CBS) and Progressive Supranuclear Palsy (PSP)

Vascular Dementia

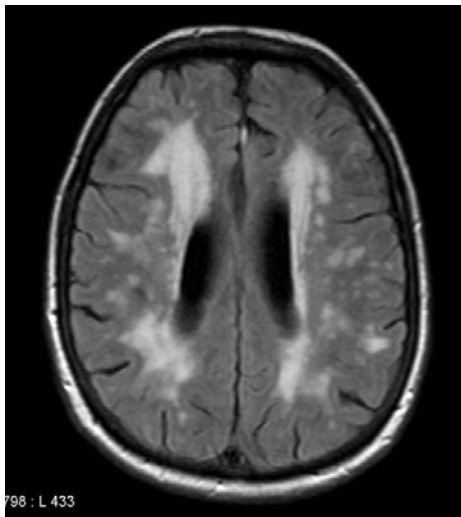
Although relatively rare in pure form (10% of cases), vascular changes often coexist with Alzheimer’s disease, and mixed dementia (Alzheimer’s plus vascular) or multiple etiology dementia is often found in older individuals. Symptoms often overlap with those of AD; history or physical exam findings may suggest stroke(s).

Normal Pressure Hydrocephalus

Normal pressure hydrocephalus (NPH) is a brain disorder in which excess cerebrospinal fluid (CSF) accumulates in the brain’s ventricles, causing thinking and reasoning problems, difficulty walking, and loss of bladder control.

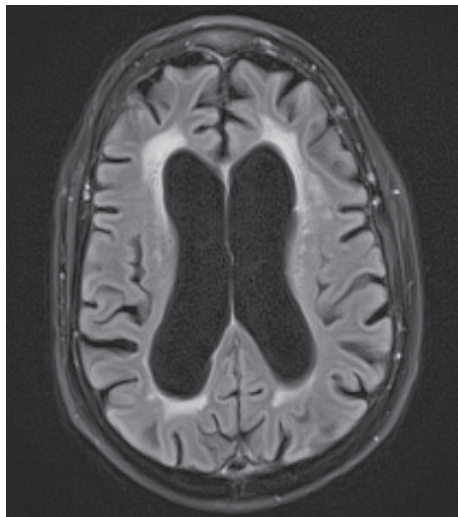


Disclosing a Diagnosis of Dementia



Vascular

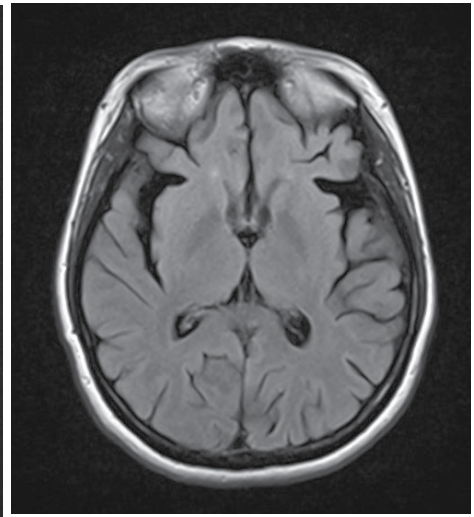
Case courtesy of Assoc Prof Frank Gaillard, <https://radiopaedia.org/>>Radiopaedia.org. From the case <https://radiopaedia.org/cases/10674>>rID: 10674



NPH

Case courtesy of Dr Mostafa El-Feky, Radiopaedia.org, rID: 75406

Online: Case courtesy of Dr Mostafa El-Feky, <https://radiopaedia.org/>>Radiopaedia.org. From the case <https://radiopaedia.org/cases/75406>>rID: 75406



FTD

Print: Case courtesy of Assoc Prof Frank Gaillard, Radiopaedia.org, rID: 50049

Online: Case courtesy of Assoc Prof Frank Gaillard, <https://radiopaedia.org/>>Radiopaedia.org. From the case <https://radiopaedia.org/cases/50049>>rID: 50049

Disclosing a Diagnosis

Once an evaluation is completed, the practitioner should be prepared to speak with the patient and caregiver or family members as a unit, and this should be done in person rather than in a virtual appointment. Often, the disclosure of a diagnosis is the maximum amount of information the patient can handle at the first post-diagnosis appointment, and the provider may want to schedule a longer, follow-up appointment to fully orient the patient and caregivers of important first steps.

The provider should assess and ask both the patient and caregiver if they feel ready to hear the results, and assess how they view the likelihood of a dementia diagnosis. How much research/reading have they already done? What has been their experience with others with dementia? What are their greatest fears?

Once the diagnosis is stated, a pause is important to gauge the response. Launching into next steps

too quickly may be overwhelming. Ask if this what they were expecting, or does it seem like a shock. Allow time for emotional responses and let tears or other emotions be expressed while maintaining compassionate eye contact or touch. This may be second nature for some clinicians but the pressure to cover the topics is always present!

Physicians may be reluctant to disclose a specific diagnosis of dementia and to mention Alzheimer's disease, as such a diagnosis may change the physician-patient relationship. Disclosure has been widely studied, and provided that it is done sensitively and with knowledge of the social and family dynamics, it is generally a helpful part of the process. Many families are relieved at obtaining closure regarding a diagnosis and explanation for the problems that they have noted. Disclosure should also include the review, assessment and discussion of medical, personal and social factors that may be impacted by dementia.

Initial discussion and disclosure may cover:

- The primary diagnosis.
- Contributing factors to the diagnosis (e.g., medical, neurological or psychiatric factors). Examples include depression, vascular risk factors, sleep disorders, medical comorbidity that may affect the brain, medications that may have cognitive side effects.
- Recommendations regarding questions such as work, driving, managing finances.
- Personal and home safety. This may include asking about firearms or other weapons if applicable, use of kitchen appliances, home safety, medications, finances (to avoid elder abuse scams), and driving. Driving is the only safety issue where there is a legal requirement of the provider to report to another agency; in this case the DMV for their review and potential testing.

At the time of disclosure, impress upon the caregiver that the patient should be given extensive social support as he/she processes the information. This may take several days or longer. Inform the caregiver how to reach you during this critical period. Acknowledge that the discussion carries with it significant impact as the patient and caregivers attempt to normalize their reaction and link response to expected needs.

If feasible, you may want to include other care professionals such as a social worker or psychologist to assist individuals and their caregivers to process the diagnosis. **Assessing the family's coping resources and offering your medical system's and community resources will be important.**

The most critical topics to cover as soon as possible include:

- Medication options:
 - o Primary and proven treatment options; disclose those that are evidence based and sufficiently studied, and explain these as standards of practice.
 - o Less well established; explain the warnings regarding research or lack thereof, the fact that these medications are chemicals whether natural or man-made.
- Driving – physician assessment of the patient's capacity to continue to drive, and when that should be re-evaluated. Physicians have a legal obligation to report patients with diminished capacity.(See resources for links to DMV). If uncomfortable making this disclosure, this would be an appropriate referral to a specialist.
- Finances and Legal Issues.

Other important topics to cover during the first year include:

- Community resources for both the individual and caregivers,
- Social resources,
- Housing: home modifications, long-term care options,
- Treatment of cognitive and behavioral symptoms,
- Management of vascular risk factors,
- Lifestyle factors such as diet, exercise, sleep, alcohol, etc.,
- Discussion of the impact of caregiving,
- Prognosis,
- Genetic questions (more appropriate for younger onset of dementia),
- Research options, enrollment in clinical trials (see Resources for Clinical Trials).

Five Action Steps Family Caregivers Should Take

- 1) Establish legal responsibility and create legal documents that will be helpful to you and to your loved one.
- 2) Understand the diagnostic process, symptoms, and course of memory loss and dementia.
- 3) Care for yourself; a healthy, rested caregiver is a more effective caregiver.
- 4) Join a support group.
- 5) Plan for the future. Do research and know what lies ahead to plan accordingly. (see handouts at back of booklet)

Initial Use of FDA Approved Medications for Cognitive Symptoms of Alzheimer's

After a diagnosis and disclosure of Alzheimer's disease, many patients and caregivers may be looking for therapeutic options. Cholinesterase inhibitors have been extensively studied for symptomatic effects on cognition in Alzheimer's disease. Clinical trials and studies show significant but small benefits vs. placebo among individuals with mild through severe Alzheimer's. Overall, they may stabilize cognition or slow its progression but do not slow the progression of the underlying disease. The most common of the cholinesterase inhibitors are: donepezil (Aricept®), rivastigmine (Exelon®) available in patch form, and galantamine (Razadyne®).

These medications can be continued as long as no negative side effects occur. Different doses of cholinesterase inhibitors are available, and usual practice is to start a patient on a low dose and titrate to a higher dose as tolerated.

Approximately 23% of patients started on donepezil will experience some element of GI adverse effect, which is the most prominent negative outcome from the agent. If a patient wishes to continue

acetylcholinesterase inhibitor therapy but cannot tolerate donepezil due to the GI effects, the practitioner can consider the rivastigmine patch, which bypasses first-pass metabolism and thereby has a lower GI adverse effect profile. If a patient experiences adverse effects, it is important to readdress therapy with the patient and/or their caregiver as any clinical adverse effect likely outweighs the statistical but not clinical benefit of the therapy. Additionally, if no benefit is shown from acetylcholinesterase inhibitors at optimal doses, it is recommended to discontinue the agent due to lack of effect. The American Geriatrics Society included this recommendation to stop acetylcholinesterase inhibitors if side effects are induced or lack of effect on cognitive tests is found in their 2014 Choosing Wisely recommendations for the American Board of Internal Medicine's Choosing Wisely initiative.¹

Memantine (Namenda®) has been shown to have small benefits on cognition and behavior in people with moderate to severe AD, either alone or added to a cholinesterase inhibitor. Memantine did not show benefit in mild AD. Memantine does not slow progress of the underlying disease. The agent has a more favorable adverse effect profile than the acetylcholinesterase inhibitors, and generally is well tolerated; however, as the clinical benefit is unknown, treatment decision should be based on the patient's preferences after a discussion of risks and benefits with the patient and/or their caregiver.²

While there are combination pharmaceuticals available, e.g., Namzaric, which combines donepezil and memantine, monotherapy is likely as efficacious as combination therapy with fewer side effects and lower cost. It is possible to combine a cholinesterase inhibitor and memantine in patients with mild AD, but randomized clinical trials have not shown the efficacy of this combination.³

There is FDA acceptable evidence that while these medications may alter several measures of dementia, many clinicians remain unsure of their benefits or impact on long term course. In addition to any benefits

Disclosing a Diagnosis of Dementia

for function or behavior, prescribing medications can offer hope to the family at a time of great distress. Practitioners should discuss and weigh risks/side effects vs benefits with patients and caregivers, and discontinue use of these medications should side effects persist.

To date, **no nutraceutical has been found to have clinical or statistical benefit for dementia.**

Non-pharmacologic interventions likely have an impact on AD, although this is harder to study and quantify. Like many chronic conditions, healthy diet, physical activity, and social interaction have been proven to be the most effective therapies for Alzheimer's disease and related dementias.

Aducanumab

On June 7, 2021, in a controversial decision, the FDA approved aducanumab under the accelerated approval pathway. This approval came despite warnings from several expert groups including the FDA's drug advisory committee and the American Geriatrics Society who felt not enough study had been conducted to conclude if there was a clinically relevant benefit. Additionally, there has been significant risk associated with the medication. The American Geriatrics Society cited the data from two phase 3 clinical trials which revealed a 30-40 percent risk of amyloid-related imaging abnormalities (ARIA) which included cerebral edema and microhemorrhages.⁴

While aducanumab has now been approved for the treatment of Alzheimer's disease, the drug's efficacy remains in question, with further study needed to ascertain what if any clinical benefit patients receiving this drug may receive. The studies conducted had discrepant results with one showing mild statistical benefit of unclear clinical significance with the other not revealing benefit. Of additional note, while the drug was approved for the indication of MCI or early stage Alzheimer's disease, it was not studied in the treatment of moderate to severe disease, and the available results are based on evaluation of patients with mild disease, confirmed amyloid deposition by PET imaging, and an MMSE of ≥ 24 .⁵ Hence, it would not be advisable to offer this treatment to patients who fall outside the inclusion criteria for the

trials conducted to date.

An additional concern with regard to aducanumab is cost. The annual cost for high-dose infusion of aducanumab is \$56,000, which does not account for costs of use of an infusion center, monitoring, or initial testing for amyloid pathophysiology. While the drug company developing aducanumab is working on means to help cover the cost of CSF testing for amyloid, other costs for the administration have not yet been accounted for, and it remains to be seen what criteria insurance companies will require and what percent of cost will be covered by insurance.

It is recommended that aducanumab only be prescribed by dementia specialists, in particular neurologists, geriatricians, or geriatric psychiatrists who specialize in and routinely care for patients with dementia; however, it is advised the primary care physician be aware of the controversy surrounding this drug. After discussion of possible risks and benefits of the drug, if the primary care physician has a patient with mild cognitive impairment or mild dementia suspected due to Alzheimer's disease wishing to receive aducanumab, a referral should be made to a dementia specialist for further assessment.

Key Take-away points:

1. Aducanumab is a new drug approved for the treatment of Alzheimer's disease with possible benefit for the earliest stages of disease
2. Treatment with aducanumab will require monthly infusions associated with a high cost burden
3. Treatment has significant risk of side effects and harm including brain bleeding and/or swelling
4. After discussing risks and benefits with your patient if they are interested in being evaluated for treatment with aducanumab they should be referred to a dementia specialist for further discussion.
5. It is vitally important to carefully and appropriately screen and evaluate patients for MCI or Alzheimer's disease in order to provide an accurate diagnosis and suggest possible management options.

Updates to this information will be posted to [ChampionsforHealth.org/alzheimers](https://championsforhealth.org/alzheimers) as they become available.

Footnotes for FDA approved medications on page 49.

Care Management through the Disease Stages

Living successfully with a diagnosis of dementia can be achieved, AND it requires planning for the different stages of disease progression. Planning involves conversations, accessing resources and supports, and receiving ongoing medical attention.

Family members and individuals with dementia often do not have the conversation about goals of care, so it is important for the provider to encourage these discussions.

Alzheimer's disease is a chronic, progressive, ultimately terminal illness. **The time course is generally around 6 – 10 years from diagnosis to death, but can vary from 3 – 20 years.**

- Common causes of death directly related to Alzheimer's disease are aspiration pneumonia and hypovolemic shock related to cessation of eating and drinking.
- Alzheimer's patients may also develop and die from other infections, including UTIs, community- or facility-acquired pneumonias, and infected pressure ulcers.
- They may also suffer strokes, myocardial infarction, arrhythmias, pulmonary emboli, and other common geriatric conditions.
- Patients may die of other causes or comorbid illnesses during the progression of their dementia.

Throughout the course of the disease, it is important for clinicians to show empathy and communicate with caregivers that the provider understands the gravity of the road they are traveling.

- This will take time to listen.
- If possible, allow for longer patient visits and schedule regular check-in appointments.

- It will be an opportunity to also assess caregiver stress and depression and recommend separate appointments for caregivers as appropriate.
- See Section on Caring for the Caregiver for more information.

Between diagnosis disclosure and end of life, there may be many years in which to educate patients and caregivers on the progress of the disease.

Fairly early on, it will be important to encourage discussion between patient and family about what the patient would like to see for their future while they have the capacity to make decisions.

- Who can clinician discuss patient care with; update HIPAA form.
- Identifying the primary decision maker.
- Creating or modifying Advance Care Directive document & POLST form.
- Appointing a Power of Attorney or fiduciary, adding family to bank accounts.
- Developing a checklist of where important documents are kept, account passwords.
- Wills and Trusts, life insurance and LTC policies, Veteran documents, etc.
- Discussing post-mortem preferences (interment/cremation/funeral service, etc.)
- Planning in case of illness of the caregiver.

Providers should remain on the alert if family members appear to be taking over all decision-making too soon:

- Encourage them not to minimize the capacities of their loved one.
- Clinicians are mandated reporters for elder abuse and fiduciary abuse when suspected.
- It is believed that most elder abuse goes unreported, and clinicians should have a low threshold to make reports to Adult Protective Services (APS) if there is any reasonable suspicion that abuse or neglect may be occurring.

- APS does not disclose sources from which they received the report to clients.

Advance Care Planning

Advance care planning is very important for patients with dementia, and should be undertaken as early as possible after diagnosis (see page 16 regarding information to discuss at diagnosis). It is prudent not to bring up advance care planning simultaneously with sharing the initial diagnosis as it is too much information for the patient and caregiver to absorb. Patients who have already formulated advance health care directives may want to update them, and those who have not completed an AHCD, and who still have decision-making capacity, as with most patients in early stage dementia, should be strongly encouraged to execute such a document immediately. These documents should make it clear who the designee(s) is to make health care decisions on their behalf if and when they become incapacitated. If there is no designee, the form is still important so that all providers know their wishes.

While POLST forms are generally recommended for those in the last year or two of life, patients with early dementia who definitely do not want aggressive interventions may wish to complete these, and their physicians should assist in this process. Specific interventions to discuss are:

- Hospitalizations
- CPR
- Intubation
- Ventilation
- Hydration
- Defibrillation
- Enteral feeding tubes
- Selective treatments and surgeries

Resources for making informed decisions can be found at:

- Coalition for Compassionate Care of California <https://coalitionccc.org>. Useful patient education pamphlets are available that review CPR,

Ventilators, Tube Feeds, Hydration. They are available in multiple languages

- Choosing Wisely website (AMDA, AAPM and AGS items at <http://choosingwisely.org/?s=feeding+tube>),
- Caring Advocates My Way Cards (<http://caringadvocates.org/card-sorting.php>)
To ascertain patient preferences through the use of cards.

Like all advance care planning discussions, these conversations can be deferred to palliative care specialists, but are meaningful and usually well accepted and appreciated when undertaken by the primary care physician who knows the patient and family best.

Topics to discuss during advance care planning conversations

CPR

It is important to note that CPR is rarely successful in the frail elderly; statistics show that it is ineffective 90 – 95% of the time for older adults, and the remaining successful resuscitations result in use of ventilators.

Tube Feeds

It is worth discussing tube feeding early on and actively discouraging consideration of a feeding tube in a patient with advanced dementia, despite family concerns about “starvation” and the tendency to associate food/nutrition with nurturing and love. In addition to the risks of aspiration, pneumonia and complications directly related to the tube (such as intra-abdominal abscesses). There is good evidence that feeding tubes are an inappropriate intervention in advanced dementia patients. In spite of that, the 2016 Dartmouth Atlas reported that in San Diego County, we are worse than the national average with respect to placing these tubes inappropriately.

Feeding tubes are associated with higher rates of delirium and pressure ulcers and have not been demonstrated to prolong life. Thickened liquids and

pureed diets, while frequently ordered, when dysphagia develops in dementia patients may not be well tolerated. Consider a palliative medicine referral if there are concerns about these issues.

Use of Ventilators

The use of ventilators for an individual with dementia could be very disorienting and can prolong an uncomfortable passing. Individuals are generally heavily sedated, and it has been shown that ventilators do not improve prognosis.

At the end of life, patients with dementia and most other illnesses lose interest in food and fluids. It is part of a natural dying process, and dying from dehydration, while it has an unpleasant reputation in the public eye, is actually one of the more benign ways to die. In fact, often no medication for symptom relief (such as opioids or benzodiazepines) is necessary. Simple measures like moistening the inside of the mouth often suffice.

Once all intake ceases, patients generally die in 7 – 14 days; these patients are usually on hospice.

Reassuring patients and families that this process is natural and appears to be painless can be very helpful and appreciated.

Avoiding Suboptimal Prescribing and Polypharmacy

Managing the care of an individual with dementia can be particularly difficult, as there may be a number of comorbid issues being addressed by a variety of subspecialists, requiring a number of prescription medications. This may result in behavioral issues (see section on Addressing Behavioral Issues for more information)

It is important to assess all medications prescribed, use the medicine most appropriate for an older patient and avoid:

- Polypharmacy (too many medications) and the prescribing cascade.
- Prescribing a medication from an essential category of medication that is not senior friendly.

- Prescribing a dose of an essential medication that is larger than needed.
- Prescribing a medication to be taken at a time of day that is not optimal (e.g. diuretics at bedtime).
- Not prescribing a needed medication (e.g. a pain medication).
- Long-term use of opiate pain medication in patients other than those with terminal cancer.

The Beers Criteria List

One of the two most widely used consensus criteria for safe medication use in older adults (the other is the Canadian criteria)

- PIMs = potentially inappropriate medications.
- Composed of 53 medications or medication classes divided into 3 categories:
 - 1) PIMs and classes to avoid in older adults,
 - 2) PIMs and classes to avoid in older adults with certain diseases that the drugs can exacerbate,
 - 3) Medications to be used with caution in older adults (new).

These criteria included designations of the quality and strength of the evidence:

- Quality of evidence is designated as high, moderate or low.
- Strength of the recommendation is designated as strong, weak or insufficient.
- Medications are organized according to organ system or therapeutic category or drug.
- The criteria also included rationale and recommendations.

The 2015 update is not as extensive as the 2012 update, but has 2 additions:

- Drugs for which dose adjustment is required based on renal function.
- Drug-drug interactions information.

Care Management through the Disease Stages

The 2019 update added medications to the following lists that are a part of the overall criteria:

- Potentially inappropriate medications for most older patients.
- Potentially inappropriate medications for those with certain conditions.
- Medications that should be used cautiously.
- Medications that have clinically important medication interactions.
- Serotonin-norepinephrine reuptake inhibitors were added to the new use-with-caution list for patients with a history of falls or fractures because they increase the risk of both.
- Although most antipsychotics are considered inappropriate for patients who have Parkinson disease with psychosis, the guidelines recommend using pimavanserin (Nuplazid), quetiapine (Seroquel), and clozapine (Clozaril) cautiously.

Transitions to Residential Care

Residential care is not the choice all caregivers make, yet providers may assess that the caregiver is unable to provide needed care or may be at risk for their own health due to caregiving. This assessment may be important to assuage guilt feelings of the caregivers. Assistance with facility selection is available through the dementia organizations included on the Resource Listing. Once an individual with dementia is living in residential care, their primary care duties may be assigned to a palliative care provider or visiting physician. It may be important to communicate to the new provider your care plans and observations.

Referral for Palliative and Hospice Care

When/how to refer for palliative care

Palliative care can be obtained at any time along the course of any serious illness, including all types of dementia. A palliative care consultation should be considered anytime the primary care physician feels that a patient, caregiver and family might benefit from

a team-based, holistic approach—whether due to issues with symptom control, conflicts over goals of care, existential or spiritual issues, or any other complex situation.

When/how to refer to hospice

Hospice can add an extra level of support for the caregiver, including social workers, faith workers and counseling services. The clinician may refer/write an order for hospice for a patient that you have anticipated has six months or less to live, and are hoping to improve the quality of life. The payment for hospice is through Medicare, VA, MediCal, or their insurance (if under 65) at no charge to patients.

Referring sooner than later can provide additional resources and support for the patient and caregiver.

There are many choices of hospice providers, both for-profit and non-profit. Patients are not required to use the hospice affiliated with the health system.

Poor prognostic indicators for Alzheimer's patients and of a time that may signal appropriateness for a hospice referral include :

- significant weight loss (e.g., 10% in 6 months),
- significant (stage 3-4) pressure ulcer development,
- dysphagia,
- recurrent upper UTIs or lower respiratory tract infections,
- marked functional decline (e.g., becoming bedbound), and
- becoming nonverbal.

Medication De-Prescribing

The geriatric mantra of de-prescribing should be initiated early and continued diligently, particularly for patients in a congregate living environment. When considering de-prescribing it is important to review on a routine basis the entirety of a patient's medication list. Each medication should be reviewed to answer the

questions of: what is the drug's purpose, is the drug granting benefit that outweighs the risk, is the drug senior friendly, is the drug dosed according to geriatric guidelines, are any drugs missing from the regimen that should be prescribed, and are there any drugs that can be consolidated to a single agent to reduce pill burden. De-prescribing includes a review of any over the counter medications or supplements.

Drugs that are high yield for review in patients with advanced dementia include:

- Anticholinergics (including common drugs for overactive bladder) promote delirium. It is advisable to use a tool such as the anticholinergic burden index for assessing which medications have anticholinergic action and attempt to minimize the total number of these agents, substituting when possible for an alternate medication.
- Antihistamines (including many OTC sleep aids that contain diphenhydramine) promote delirium. These should be utilized with caution, if at all, in patients with dementia.
- Opioids, sedatives, and some classes of antidepressants increase the risk of falls.
- Blood pressure medications: The JNC-8 guidelines recommend a blood pressure target of less than 150/90 for the elderly so as to avoid hypotension and minimize falls. Certain blood pressure medications are on the Beer's list as ones to avoid in the elderly most notably hydrochlorothiazide and clonidine due to risk of falls.
- Consider stopping all non-essential drugs, especially those that require many years to show benefit. For instance, if an elderly patient with dementia is taking a baby aspirin or statin for primary prevention it is likely that neither of these medications' benefits outweigh their risks and should be stopped.
- Antipsychotics are dangerous and should be used as a last resort for extreme behavioral or psychotic symptoms (such as frightening hallucinations).
- Benzodiazepines tend to disinhibit behavior, sometimes exaggerating rather than alleviating anxiety or agitation. They should be avoided whenever possible.
- Cholinesterase inhibitors and memantine have their own side effects (especially nausea, anorexia and bradycardia for the cholinesterase inhibitors) which may become severe in patients with advanced AD, and when the patient is already institutionalized, or they are progressing despite the medications, strong consideration should be given to discontinuing these drugs.

Certain vitamins and over the counter supplements can have adverse effect in the elderly. For instance, multivitamins with minerals contain iron which increases the risk of constipation, which if unrecognized can be a delirium contributing factor. The literature does not support the use of multivitamins in the elderly due to lack of any morbidity or mortality benefit, but rather a targeted supplementation with vitamins based on laboratory finding of specific vitamin deficiencies. (Ann Intern Med. 2006;145(5):364; Arch Intern Med. 2011;171(18):1625).

No supplements for "cognitive enhancing" are recommended. To date evidence has not supported the use of supplements such as vitamin E, Prevagen, zinc, and other agents have had no consistent evidence of benefit but risk of significant drug-drug interactions such as ginkgo biloba. When weighing the risks and benefits of homeopathic agents it is especially important in the elderly to consider how the agent will interact with prescribed pharmaceuticals.

A case in point is that of Percepta, which is a homeopathic agent marketed as a "memory support." The core component of Percepta is Cat's Claw, which is an herb that is a potent inhibitor of CYP3A4 and hence can interact with many prescribed medications including anticoagulants, statins, HIV medications, and diuretics. Additionally Cat's Claw has been shown to increase bleeding risk which could have a significant morbidity for the elderly. As there has not been

rigorous study of Cat's Claw it is unclear if there is any benefit to this homeopathic pill, but the risks associated with it are substantial and hence a risk-benefit analysis would argue against its use.

More information on drugs that are potentially inappropriate in older patients is available on pages 33-34, and on the Beers List through the American Geriatrics Society: <https://www.elderconsult.com/wp-content/uploads/PrintableBeersPocketCard.pdf>

More information on supplements and dementia can be found at:

<https://www.nccih.nih.gov/health/providers/digest/dietary-supplements-and-cognitive-function-dementia-and-alzheimers-disease-science>

Management of Behavioral Symptoms of Dementia

Although cognitive impairment is the clinical hallmark of dementia, behavioral and psychological signs and symptoms of dementia (BPSD), which are also known as non-cognitive neuropsychiatric symptoms (NPS), are extremely common and are responsible for the majority of pain and suffering experienced by the individuals living with dementia and those who love and care for them. In addition, BPSD is a primary factor responsible for the medical and other costs associated with caring for individuals living with dementia. BPSD accounts for at least 30% percent of the cost of caring for community dwelling individuals with dementia.

Research has found that BPSD is associated with:

- 1) Reduced quality of life for patients living with dementia,
- 2) Reduced quality of life for family members and caregivers,
- 3) Early nursing home placement,
- 4) Hospital admissions,
- 5) Avoidable morbidity and mortality,
- 6) Caregiver stress and depression,
- 7) Reduced caregiver employment income.

The assessment and treatment of BPSD is not simple. BPSD is the result of the interaction of numerous possible factors that are internal and external to the individual living with dementia, including the brain disease responsible for the dementia and the environment in which the individual with dementia is living.

A number of groups and organizations have developed and published excellent algorithms, treatment guidelines and other resources to help clinicians and family members accurately diagnose and treat BPSD, and many are included as references in this manuscript. The goal of this section is to succinctly summarize previously developed information with references so that the treating provider can easily obtain additional and more detailed information when necessary, and so that the provider knows when to seek consultation

from a specialist in this area. Specifically, this guide contains an assessment and treatment algorithm, a number of guidelines for assessing and treating some of the most common forms of BPSD, and a form for caregivers to use when preparing to meet with a clinician in order to obtain help with BPSD.

DICE: Describe, Investigate, Create, Evaluate.

Helen Kales, MD, and her colleagues at the University of Michigan authored the DICE algorithm, which the Clinical Roundtable recommends. These guidelines emphasize the importance of creating an accurate description of the behaviors in the medical record, undertaking a systematic investigation of their cause(s), using the safest and most precisely targeted interventions possible, and periodically reassessing to determine if the interventions are working and if they are still needed.

DICE stands for Describe, Investigate, Create, and Evaluate. The algorithm summarized in the tables on pages 36-40 provide the practitioner with tools for convenient consultation in the middle of a busy day. This document also contains more detailed information on the use of the treatment options, as well as references and resources. There are many factors that may make the investigation of the etiology of BPSD and its treatment difficult. While most dementia and associated behavioral symptoms are screened, diagnosed and treated by the primary care provider, it is always advised to refer the patient to a geriatric internal medicine specialist, neurologist, psychiatrist, or geriatric psychiatrist if the primary care practitioner is unsure or uncomfortable with the evaluation or treatment.

DESCRIBE

When an individual living with dementia develops behavioral symptoms, the clinician should guard against jumping to the conclusion that the symptoms are exclusively and intrinsically an expected outcome of the dementia illness. A somewhat liberal and

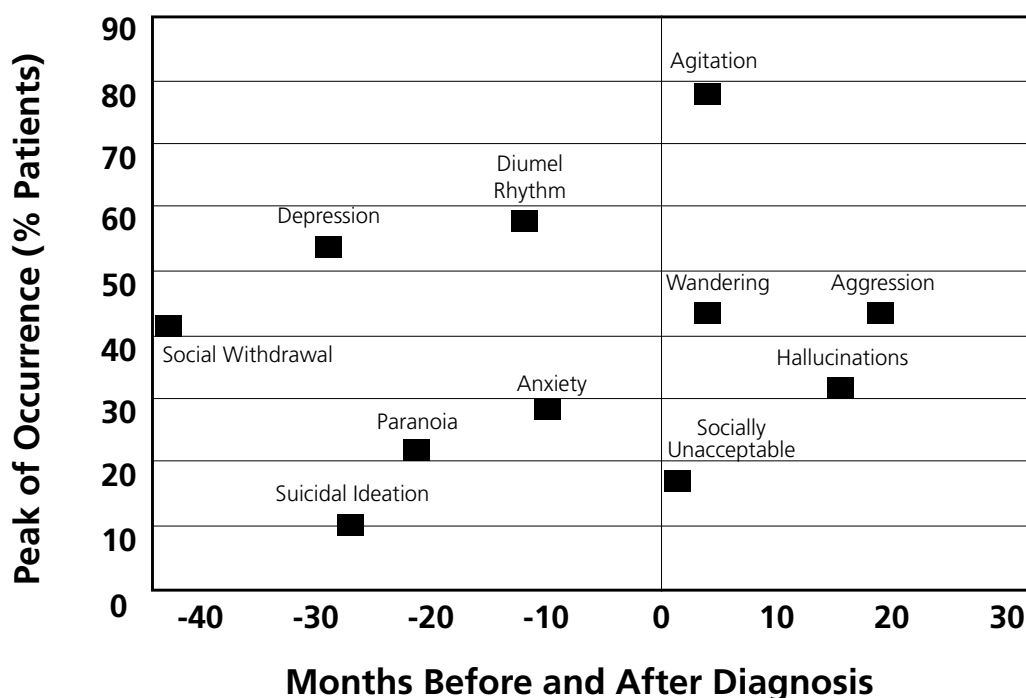
Management of Behavioral Symptoms of Dementia

yet compassionate and useful perspective is to view problem behavior or behaviors as a form of communication limited, perhaps, by the cognitive losses that are occurring as part of the dementia. This perspective mandates that the clinician assume the stance of a scientist or private investigator and begin to systematically collect information that will ultimately lead to an understanding of the causes and associated best remedies of the behavior(s). This is, in essence, the underlying premise of the DICE approach. Although this approach may consume more time and other resources up front, in the long run the benefits in terms of improved quality of life for all involved and decreased healthcare expenditures, will far surpass these costs.

Common Behavioral Problems:

- Food Refusal
- Restlessness
- Combativeness
- Hypersexuality
- Depression
- ADL refusal
- Medication refusal
- Agitation
- Wandering
- Sleep disturbances
- Disinhibition
- Irritability
- Psychosis
- Social withdrawal
- Anxiety
- Aggression

Disease stages and symptoms. In patients living with Alzheimer's dementia, research has demonstrated that certain symptoms are most likely to occur at certain stages of the illness. Knowing this is very helpful because if a symptom like physical aggression occurs early in the course this strongly suggests that the symptom may be related to medical illness or some other psychiatric illness other than the dementia. Below is a graph depicting when specific symptoms of BPSD are most likely to occur over the course of the dementia illness.



Source: Jost BC, et al. *J Am Geriatr Soc.* 1996;44:1078-1081

INVESTIGATE

Critical to the effective management of behavioral issues or symptoms is the thorough investigation of the underlying causes of these behaviors. Consider these:

Ten Key Points to Consider

- 1 New or rapidly worsening behavioral symptoms in a patient with dementia should be considered a sign of an underlying medical illness until proven otherwise.
- 2 Assess whether a new or recurrent underlying medical factor may be involved.
- 3 Problem behaviors are often triggered by anticholinergic medications and suboptimal prescribing.
- 4 Obtain a careful history focused on potential environmental antecedents and any changes in the patient's medical status and medications.
- 5 Understanding the differences between the psychotic symptoms typically seen in patients with dementia versus the psychosis seen other conditions will help refine the differential diagnosis.
- 6 The concept "psychobehavioral metaphor" may help with selection of a class of medication with the highest probability of being helpful.
- 7 In spite of the recent FDA warnings, in certain situations a risk-to-benefit analysis may still favor the use of antipsychotic medications.
- 8 Other possibly helpful medication strategies not FDA-approved for treatment of BPSD and best prescribed by a specialist include: prazosin (Minipress®), dextromethorphan-quinidine (Nuedexta®) and pimavanserin (Nulpazid®), which is FDA-approved for the treatment of Parkinson's disease psychosis.
- 9 The use of both pharmacological and behavioral strategies leads to the best results.
- 10 Remember that symptoms evolve over the stages of dementia and may decrease or disappear.

Differential Diagnosis of Behavioral Symptoms in a Patient with Dementia

Consider using the concept, psychobehavioral metaphor, first described by psychiatrist Pierre Tariot, MD, when attempting to discern the most likely common psychiatric syndrome occurring in a patient who is living with dementia. In essence, the concept invites the clinician to ask him or herself, "if I did not know that this patient had dementia, what common psychiatric syndrome or diagnosis would the signs and symptoms this patient has most resemble?" A concept closely related to the psychobehavioral metaphor which has been described by Lawlor and Bhriain (2001) has been called "BPSD clusters." These clusters include: Depression, Apathy, Aggression, Psychomotor Agitation and Psychosis.

Differential diagnosis categories include:

Medical: constipation, hypoglycemia, pain, suboptimal prescribing, urinary tract infection,

Psychiatric: anxiety, depression, impulsivity, mania, paranoia,

Psychological: abandonment anxiety, boredom, frustration, loneliness, TV violence,

Other: fatigue, hunger, noise, movement restriction, thirst, suboptimal communication, uncorrected sensory deficits.

Etiologic categories of the medical differential diagnosis include:

- Delirium
- Exacerbation of pre-existing medical illness
- Onset of new medical problem
- Medication toxicity (e.g. polypharmacy or suboptimal prescribing)
- Drug or alcohol intoxication or withdrawal
- Exacerbation of pre-existing psychiatric illness
- Onset of a new psychiatric illness

Management of Behavioral Symptoms of Dementia

Medical illnesses are often overlooked in older patients, especially those with psychiatric diagnoses or dementia prominently highlighted in their records!

Common “Delusions” in Patients with Dementia

Delusions are a common behavioral issue among individuals with dementia. Delusions associated with Alzheimer’s dementia are simple and plausible. The presence of complex or bizarre delusions strongly suggests the presence of a pre-existing psychiatric disorder. The most frequent delusions associated with Alzheimer’s are:

- Accusations of infidelity
- Persons or images from TV are real
- Fear of abandonment
- Accusations of theft of one’s property
- Claims of impersonation (spouse is imposter)
- Current residence is not one’s home
- Misidentification of familiar persons

Recognizing Delirium

Research has found that as many as one-third of older adults who present for evaluation and treatment of new or worsening behavioral symptoms have these symptoms due to a medical problem that has not yet been accurately diagnosed and/or optimally treated (Woo et al.). In many instances, the presence of these medical illnesses has resulted in the development of delirium.

The recognition of the presence of delirium rests upon having a high index of suspicion. The following questions may help determine whether the patient is experiencing delirium:

- Have there been any recent medication changes?
- Does the patient look physically ill or physically uncomfortable?
- Are the patient’s vital signs reasonable?
- Are the patient’s vital signs around their usual baseline?
- Are the patient’s lab values reasonable?

- Has the patient’s mental status changed rather suddenly or dramatically?
- Is the patient suddenly behaving in ways that have never been characteristic for the patient?
- Is the patient’s level of alertness and/or attention waxing and waning?

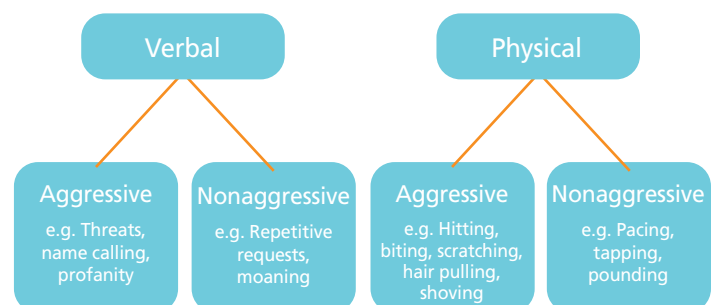
Maintain vigilance for “Stealth” Anticholinergic Medications: All sorts of medications can cause delirium but be especially watchful for those with anticholinergic properties and remember that the anticholinergic properties of some medications may be overlooked (e.g. digoxin, furosemide, warfarin).

Assessment and Treatment of Depression

An episode of major depressive disorder in older individuals may not look the same as in younger patients. Remember that diagnosing an episode of major depressive disorder through the veil of dementia is difficult and it may be impossible to identify all of the signs and symptoms usually required to make a definite diagnosis. For example, a patient with dementia may have such severe aphasia that they are unable to answer questions about self-esteem or anhedonia or the presence of rapid forgetting may prevent the patient from providing an accurate history of sleep or appetite.

Assessment and Treatment of Agitation

All agitation is not the same and, therefore, should not be treated the same. The algorithm provides examples of four types of agitation that have different triggers and, as a result, have different optimal treatments.



Source: Cohen-Mansfield J, Marx MS, Rosenthal AS. A description of agitation in a nursing home. Journal of Gerontology: Medical Sciences 1989;44(3):M77–M84.

In spite of the FDA black box warnings, antipsychotics may still be the best pharmacologic treatment option in patients with BPSD, especially in patients whose behavioral symptoms seem to be triggered by delusions or in patients who have a clear history of a psychiatric disorder that included psychotic symptoms and preceded the onset of dementia illness (e.g. a mood disorder with psychotic features or schizophrenia).

Whenever possible, medication changes (e.g. additions, discontinuations, dose amount adjustments, and changes in medication timing or frequencies), should occur one at a time and with sufficient time in between in order to more accurately evaluate the impact of the medication change prior to another medication change being made.

Factors influencing investigation. There are many factors that may make the investigation of the etiology of BPSD, and its subsequent treatment, difficult. These factors include but are not limited to:

- The limited time that many healthcare systems allot for outpatient clinical appointments.
- The extra time and resources needed to properly examine a patient with BPSD. For example, severe constipation (obstipation) has been identified as a common trigger of BPSD and yet accurately diagnosing constipation in a patient living with dementia is more challenging for a variety of reasons. Often the patient with BPSD is unwilling or unable to cooperate with key components of the evaluation including the provision of accurate history and/or a digital rectal examination. Extra personnel may be needed to assist with the physical examination in order to ensure patient and examiner comfort and safety.
- The **difficulty** that many patients living with dementia have in providing **clear, concise accurate** historical information.
- The difficulty that many caregivers, especially family caregivers who are exhausted by the demands of caregiving, have in providing clear, concise, accurate historical information.

- The lack of optimal training experiences of many of the clinicians who are on the frontlines in the assessment and treatment of BPSD.
- An insufficient number of well-trained experts who are prepared to diagnose and treat patients with BPSD.

The use of rating scales to assess the severity of symptoms, to provide documentation to justify the costs of care and to monitor more objectively the impact of interventions is recommended. The rating scales recommended by Tampi et al. have been included on page 96.

The importance of searching for **medical triggers** cannot be overemphasized. Published research including the work by Woo et al., have found that a significant subset of older individuals, including those who may be living with dementia, are experiencing the problem behaviors due to previously undiagnosed (and therefore untreated medical problems) or due to medical problems that have not been optimally treated.

CREATE a Care Management Plan

Disease Management: General Concepts

- Define and document target symptoms.
- Identify and optimally treat all medical conditions.
- Identify and remove triggers (e.g. pain, noise, boredom, hunger...).
- Use all possible helpful tools.
- Depending on acuity of behavior, use behavioral interventions first.
- There is no US FDA-approved treatment for behavioral disturbance associated with dementia.
- Combine behavioral and medication interventions.
- Use the psychobehavioral metaphor (defined in the algorithm chart on page 36 and in the text on page 27) to select initial class of medication.

Behavioral and Environmental Management of BPSD

It is advised to develop behavioral intervention strategies with the family members and caregivers prior to utilization of pharmacological management. The algorithms included in this document offer a variety of treatment suggestions for use by caregivers. Educate and advise them of these essentials:

Create a safe, comfortable environment:

- Assess whether the amount of stimulation in the environment is optimal based on the patient's preferences and behaviors and then make the indicated adjustment.
- Assure adequate lighting and comfortable ambient temperature.
- Establish routines and provide structured activities.
- Explore using photographs or music to stimulate calming memories or prevent boredom.
- Provide an environment with a secured perimeter in which the patient can move about freely.
- Provide furniture with strong arm rests and seats at a comfortable height with firm cushions.
- Turn on bright lights in the home, or take the patient outdoors with appropriate solar protection, in late afternoon to avoid sundowning.

Improve suboptimal communication in order to achieve desired behavioral results. Examples of suboptimal communications include:

- Making more than one request at a time.
- Not allowing time for the person living with dementia to respond.
- Not assuming a comfortable, relaxed posture.
- Not identifying and verbalizing the patient's affect.
- Not maintaining eye contact.
- Not using more than one sensory modality.
- Not using simple, direct statements.
- Speaking too fast or with poor diction.

Redirection helps to improve communications, and helps the patient refocus in order to be calmer, cooperative, content, and safe. Physicians can refer caregivers to the Communication Tip Sheet in the back of this book.

See the Resources for Caregivers for additional information.

Care Refusal

The caregivers should be coached on dealing with difficult behaviors including the refusal of care. Many factors may be involved in these situations, including anger, anxiety, confusion, fear, occupational history (e.g. a career as a CEO), pre-existing personality characteristics (always being fiercely independent), and verbal or physical agitation or aggression due to delirium. The most common forms of care which are refused are bathing, eating, clinical appointments, and medications.

Caregivers should be encouraged to:

- Avoid arguments.
- Communicate that both the request and refusal is understood.
- Identify and verbalize the emotions which the patient is experiencing.
- Keep the emotional intensity of the interaction as low as possible.
- Remember who the patient was prior to the onset of dementia.
- Shift the focus to a pleasant experience and then reattempt later.

Refer the caregiver to resources to assist with these behaviors. *See Resource Sheet.*

Pharmacologic Management of BPSD

FDA approved use of cholinesterase inhibitors and memantine may have a role to play in the treatment of BPSD. They may also contribute to the development of BPSD. If a patient presents with BPSD and is currently

taking a cognitive enhancer and/or memantine, efforts should be made to determine if there may be a temporal association between the initiation of treatment and the emergence of BPSD. If a patient with BPSD is not yet taking a cognitive enhancer or memantine, then the addition of a cognitive enhancer or memantine should occur as one of the final steps in symptom management and only after the most pressing behavioral symptoms have been successfully addressed.

A cognitive enhancer or memantine should be added sequentially and only after it has been confirmed that the addition of the first medication has not caused problems. See page 17 for more information on these medications.

Psychotropic Medication Management. It is important for clinicians involved with the assessment and treatment of BPSD to remember that with only rare exceptions, most types of dementia are progressive neurocognitive illnesses which means that the underlying disease process leads to ever increasing damage to the afflicted individual's brain. This reality sometimes leads to worsening behavioral challenges but sometimes leads to improvement in problem behaviors whenever the brain tissue centrally involved in triggering the behavior is damaged and no longer able to play a causal role in the behavior's occurrence.

Once a patient with BPSD has been stable for 3-6 months, if psychotropic medication has been required to manage the behavior, it is then important to initiate a cautious, incremental reduction in psychotropic medication and monitor the patient closely. If the problem behavior(s) does (do) not reappear after several weeks, then another reduction should occur. On the other hand, if at any point a reduction leads to the return of a problem behavior, then the patient should be returned to the dose at which the problem behavior remained in remission.

Pharmacologic Treatment: General Principles

- Avoid long-term use of opioid medications and attempt to taper and remove whenever possible.
- Behavioral symptoms vary according to stage of illness and may remit as the illness progresses.
- Check the timing of medication dose against other issues, i.e., diuretics at bedtime should be avoided.
- Refer to the PDR or comparable reference for information on introducing and titrating medication.
- Remember that older adults usually need lower dosages.
- Start low, go slow and determine lowest effective dose or,
- Start low, increase relatively swiftly and then be prepared for the need to back off in order to determine lowest effective dose.
- Use medications better tolerated by older adults (often these are renally excreted).
- Withdraw after an appropriate period and observe for relapse.

Categories of Medications Which May be Helpful:

- Alpha adrenergic blockers
- Antipsychotics
- Antidepressants
- Anxiolytics
- Beta blockers
- Cholinesterase inhibitors
- Dextromethorphan-quinidine
- Hormones
- Memantin
- Mood stabilizers
- Pain medications especially routine acetaminophen

Benzodiazepines

- Short-acting, renally excreted agents are preferred
- Lorazepam (Ativan®)
- Oxazepam (Serax®)

Other Medications That May Prove Helpful

Dextromethorphan/quinidine - Dextromethorphan hydrobromide and quinidine sulfate (Nuedexta®) is approved for pseudobulbar affect (PBA) in the US and European Union. Limited effectiveness and the risk of falls and interactions with other medications resulted in its addition to the Beers list in 2019 and because of this should be used only when the patient's dementia has caused PBA.

Dextromethorphan is most well-known as a cough suppressant

- a low low-affinity, uncompetitive NMDA receptor antagonist,
- $\sigma 1$ (sigma1) receptor agonist,
- Serotonin and norepinephrine reuptake inhibitor,
- Neuronal nicotinic $\alpha 3 \beta 4$ receptor antagonist,
- Quinidine is a Class 1 antiarrhythmic,
- When combined with dextromethorphan, quinidine works by increasing the amount of dextromethorphan in the body.

Dosing in PBA:

- Combination of dextromethorphan (20 mg) & quinidine (10 mg) comes as a capsule to be taken orally with or without food.
- Starting dosage: 1x day for 7 days, then every 12 hours.
- More than two doses should not be taking in a 24-hour period; medication should be taken around the same times each day.
- Drug-Drug interactions: desipramine (levels increase 8-fold), paroxetine (2-fold increase), MAOIs and memantine.

Prazosin (Minipress®) - The noradrenergic system is the brain "adrenalin" system for attention and arousal. Excessive noradrenergic reactivity produces anxiety and agitation, and contributes to agitation in AD. Prazosin is an alpha-1 receptor antagonist, and crosses the blood/brain barrier. It is non-sedating, does not cause parkinsonism but may reduce BP. It is shown to have long-lasting benefits in PTSD. In AD, dosing is between one and six mg per day.

Trazodone (Desyrel®) – there is no good data for the use of this medication based on Cochran Reports. Practitioners have found this medication may treat both acute agitation and prevent further episodes, and may be a good choice for insomnia. Dose range is 25 – 100 mg; complete response may take two to four weeks. Sedation is common, and priapism is very rare in older adults.



Antipsychotic Medications

Drug	Dose
Aripiprazole (Abilify)	4 forms including tablets (2, 5, 10, 15, 20, 30 mg), DiscMelt (10 and 15 mg), liquid and IM
Asenapine (Saphris)	2.5 mg & 5 mg sublingual; q12 hours
Cariprazine (Vraylar)	Capsules (1.5, 3, 4.5 and 6 mg)
Clozapine (Clozaril)	Refer to psychiatrist
Illoperidone (Fanapt)	Tablets (1, 2, 4, 6 mg); q 12 hours
Lurasidone (Latuda)	Tablets (20, 40, 60, 80 mg)
Olanzapine (Zyprexa)	4 forms including tablets (2.5, 5, 7.5, 10, 15, 20 mg) Zydys (5, 10, 15, 20 mg), IM, IM ER
Paliperidone (Invega)	Tablets (1.5, 3, 6 and 9 mg) Max = 12 mg, Renal = 3 mg
Pimavanserin (Nuplazid)	Tablet 17 mg (FDA for Parkinson's disease psychosis)
Quetiapine (Seroquel)	Tabs (25, 50, 100, 200 mg) q 12 hours; Extended release tabs (50, 150, 200, 300, 400 mg)
Risperidone (Risperdal)	4 forms including tablets and M-Tabs (0.25, 0.5, 1, 2, 3, 4 mg), liquid, Risperdal Consta (q 2 weeks)

Antidepressant Medications

Drug	Dose
Citalopram	10, 20 and 40 mg tabs (20 and 40s are scored). Starting dose is 10 mg. Max dose = 40 mg. Doses above 40 mg not recommended due to QTc prolongation.
Escitalopram	5, 10 and 20 mg (10 and 20s are scored). Starting dose is 5 mg. Max dose = 20.
Sertraline	25, 50 100 tabs plus oral solution. Starting dose = 25 mg. Max dose = 200 mg.
Duloxetine	20, 30, 60 mg tabs. Starting dose 20 mg. Max dose = 60 mg.

NOTE:

- 1) These are generally considered the best choices for older adults but other factors like previous treatment history or family history may influence your choice.
- 2) If you prescribed any two antidepressant medications for a particular patient without success, then a referral to a psychiatrist is recommended.

Mood Stabilizing Medications

Drug	Dose
Divalproex	Sprinkles 125; , DR 125, 250 500 mg; ER 250 and 500 mg. Oral solution: 250 mg/5 ml. Starting dose = 125 to 250 mg. Dose is determined by clinical response and blood level of total valproic acid (50 to 100 µg/ml). When converting to ER, increase dose by 20%.
Lithium	Tablets, capsules, oral solution; and ER. 300 mg tabs. ER comes in 300 and 450s. Solution: 8 mEq/5 ml. Recommended trough serum range is 0.4 to 0.8 mmol/L. Starting dose = 300 mg.
Gabapentin	Capsules 150, 300, 400 mg; Tablets 600 and 800; liquid. Starting dose 150 to 300 mg; Max dose = 3600 mg in a divided dose.
Pregabalin	Caps: 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg, and 300 mg. Oral Solution: 20 mg/mL.

The risks of the interventions provided, and the speed of their implementation should be in direct proportion to the pain and dangerousness of the behaviors. Sometimes, the use of less precise medication interventions is needed initially in order to facilitate the investigation for underlying causes.

Factors to consider in the creation of a care plan include:

Health system traditions, regulations and policies, including:

- Many insurance plans do not yet pay for services that would often help reduce the frequency and intensity of BPSD. For example, adult day healthcare programs that specialize in the care of patients living with dementia are often not affordable for many individuals living with dementia in spite of their proven benefits. These benefits include increasing the quality of life of individuals living with dementia, reducing rates of illness and burn out in family caregivers, reducing the rates of BPSD by providing meaningful and enjoyable activities for patients and the delaying or even prevention of placement in residential care, which is the most expensive method of caring for those living with dementia illnesses.

- The emphasis on keeping the duration of hospitalizations as brief as possible which may sometimes tempt clinicians to make too many changes in care at the same time which, in some instances, makes it difficult to know precisely which intervention was responsible for improvement or, possibly, in worsening of the behaviors. This emphasis may also tempt prescribers to place patients on doses of medication larger than truly needed in order to reduce problem behaviors sufficiently to permit a patient to be discharged to a lower and less expensive level of care.
- The lack of appropriate healthcare facilities that are designed to care for older patients who have concurrent medical and psychiatric problems that needs to be assessed and treated in tandem. For example, most inpatient psychiatric units are not able to care for patients who may require intravenous therapy, and most medical and surgical inpatient units are not designed to handle disruptive behaviors and so often must resort to cautious and judicious use of physical restraints which themselves often may trigger or perpetuate problem behaviors.

Shortage of Clinicians.

Given the huge mismatch between the projected number of individuals who will be afflicted with dementia and the number of clinicians who have completed specialized training programs to prepare them to efficiently and safely diagnose and treat BPSD, most of this work will be undertaken by clinicians who will need resources like this manuscript in order to provide the care that these patients need.

In general, if the application of the information in this document does not result in acceptable clinical outcomes, then making a referral to a board-certified neurologist, geriatric internist, general psychiatrist or geriatric psychiatrist is recommended. In particular, if you are considering the use of any of the above medications listed under the category of “Other Medications That May Prove Helpful,” then a consultation with or a referral to a neurologist, geriatric internist, general psychiatrist or geriatric psychiatrist is highly recommended.

See information on prior pages regarding medication management for patients living with advanced AD.

EVALUATE (Re-Evaluate)

It is important to review whether the interventions employed and implemented by caregivers have been safe and effective. An initial evaluation should be done within two to three weeks, and modifications made as needed. The practitioners should continue to look for possible underlying causes of behavioral factors. If the patient is stable for three to six months on psychotropic medication, initiate a cautious incremental reduction, and monitor the patient closely. If symptoms reappear after the dose reduction, then restore the dose to the level at which no symptoms were observed and wait another 3-6 months before re-attempting a dose reduction. If symptoms do not re-emerge after about 4 weeks, then make another reduction. If a variety of interventions are not effective, or if the patient or caregiver is in danger, consider referral to a neurologist, geriatric internist, general psychiatrist or geriatric psychiatrist.

DICE APPROACH TO BEHAVIORAL AND PSYCHOLOGICAL SIGNS AND SYMPTOMS OF DEMENTIA

DESCRIBE

Caregiver describes behavioral factors:

- Social & physical environment
- Patient perspective
- Degree of distress to patient and caregiver

Look for:

- Antecedents
- Context
- Patterns
- Co-occurring events

INVESTIGATE (ASSESS)

Investigate possible causes of behavior:

- Medication side effects
- Pain
- Functional limitations
- Medical conditions
- Psychiatric comorbidity
- Severity of cog impairment
- Degree of executive dysfunction
- Poor sleep
- Sensory changes
- Emotional triggers: ie., fear, abandonment
- Lack of physical activity
- Suboptimal exposure to bright light

CREATE (TREATMENT)

Provider, caregivers, clinical team collaborate to create and implement a treatment plan

Address physical problems and medical issues first

Employ behavioral interventions

- Provide caregiver interventions
- Enhance communication
- Create meaningful activities
- Simplify tasks

Ensure that the environment is safe

Increase or decrease the amount of stimulation in the environment

If behavioral interventions not effective/partially effective, employ pharmacological management, selecting a class of psychotropic medication based on psychobehavioral "Assume/Assess/Align" model, as below

ASSUME patient does not have dementia

ASSESS psychiatric signs and symptoms

ALIGN symptoms to best fit psychiatric syndrome eg., major depression, paranoid psychosis, mania, etc.

EVALUATE (AND RE-EVALUATE)

Evaluate whether "CREATE" interventions implemented by caregiver(s) have been safe/effective

- Make modifications as needed and continue to look for possible underlying causes
- Re-evaluate periodically
- If intervention not effective or if patient or caregiver are in danger, consider referring to neurologist or psychiatrist

THE ALZHEIMER'S PROJECT



DICE APPROACH FOR BEHAVIORAL AND PHARMACOLOGIC TREATMENT OF DEPRESSION

DESCRIBE

Symptoms overlap with behavioral symptoms of dementia. Depressed mood may not be evident in older patients with major depression. Consider the following in older patients: anxiety, insomnia, anorexia, irritability, anger/hostility, insecurity, paranoia, etc.

Presenting symptoms: Depressed mood, tearfulness, anxiety, anhedonia, anorexia, weight loss, insomnia, hypersomnia, irritability, pessimism, suicidal ideation, somatic preoccupation, decreased concentration, psychomotor slowing, social isolation, psychosis.

INVESTIGATE (ASSESS)

- **Evaluate** underlying medical causes including medication side effects; work-up significant cognitive impairment/dementia.
- **Do not assume** cognitive impairment is solely due to depression.
- **Evaluate for the following:** social/family support, past psychiatric and substance abuse history, family mental health history.

CREATE (TREATMENT)

Educate - patient and family; provide psychosocial interventions to support both patient and caregivers.

Medication - Antidepressant medication should be started at low dose and increased slowly. Preferred antidepressant in older adults include citalopram, escitalopram

Psychiatric consultation - consider in context of severe depression, failure to thrive, psychosis, suicidal ideation, history of major psychiatric illness (eg. bipolar disorder, schizophrenia, past suicidal attempts, severe agitation, etc.)

EVALUATE (AND RE-EVALUATE)

Gather information - from caregivers and patient; use rating scales to track response to treatment.

Medication response - Evaluate for side effects of medication within 2 weeks and efficacy within 3-4 weeks.

Evaluate for consultation - Worsening symptoms or adverse effects of treatment (worsening cognitive symptoms, increased agitation, worsening insomnia, new suicidal ideation, etc.) should lead to psychiatric consultation.

THE ALZHEIMER'S PROJECT

DICE APPROACH FOR BEHAVIORAL AND PHARMACOLOGIC TREATMENT OF AGITATION & AGGRESSION

DESCRIBE

Verbal Agitation

- Aggressive vs Non-Aggressive

Physical Agitation

- Aggressive vs Non-Aggressive

INVESTIGATE (ASSESS)

Agitation Type

Verbal Non-aggressive

Exhibits As

Loud Screaming or Moaning, Requests for Help

Potential Underlying Cause

Depression, Anxiety, Boredom

Verbal Aggressive

Threats, Name Calling

Paranoia

Physical Non-Aggressive

Pacing, Repetitive Pounding

Disinhibition, Boredom, Need for Attention, Companionship

Physical Aggressive

Hitting/Kicking/Pushing

Pain disorder or physical discomfort associated with movement, or constipation

CREATE (TREATMENT)

Address physical problems and/or utilize behavioral modifications. For behavioral specific resources:

www.alz.org/care

The 36 Hour Day by Nancy L. Mace & Peter V. Rabins

Ensure environment is safe with appropriate stimulation

If treatment of physical problems and/or behavioral modifications do not control behaviors consider pharmacologic treatment — Examples:

- Irritability/depression - antidepressant
- Fear/paranoia - antipsychotic
- Disinhibition/embarrassment - mood stabilizer
- Movement/pain - analgesic

EVALUATE (AND RE-EVALUATE)

***If patient stable 3-6 months, and psychotropic medication has been required, initiate a cautious incremental reduction and monitor patient closely**

- If symptoms are not fully resolved, look for other underlying causes
- If intervention not effective or if patient or caregiver are in danger, consider referring to neurologist or psychiatrist

THE ALZHEIMER'S PROJECT

DICE APPROACH FOR ASSESSMENT AND TREATMENT OF SLEEP PROBLEMS

DESCRIBE	<p>Sundowning Daytime Sleeping Sleep Fragmentation</p> <p>Initial Insomnia Middle Insomnia</p>
INVESTIGATE (ASSESS)	<p>Pain Osteoarthritis Sleep Apnea or Orthopnea</p> <p>Boredom Poor Sleep Hygiene Suboptimal Prescribing</p>
CREATE (TREATMENT)	<p>Educate on good sleep hygiene practices Correct any potential medical problems</p> <p>If strict application of sleep hygiene practices and successful treatment of all medical co-morbidities has not resolved the insomnia problem, consider insomnia as potential symptoms of a psychiatric disorder and apply the psychobehavioral methaphor. If insomnia appears to be related to temporary/situational factors, consider use of very low dose FDA approved medication for insomnia.*</p>
EVALUATE (AND RE-EVALUATE)	<p>*If patient stable 3-6 months, and psychotropic medication has been required, initiate a cautious incremental reduction and monitor patient closely</p> <ul style="list-style-type: none"> • If symptoms are not fully resolved, look for other underlying causes • If intervention not effective or if patient or caregiver are in danger, consider referring to geriatric neurologist or psychiatrist

THE ALZHEIMER'S PROJECT

DICE APPROACH FOR WANDERING

DESCRIBE	<p>Wandering May occur in indoor residential or commercial environments as well as outdoor areas with or without secured perimeter</p>
INVESTIGATE (ASSESS)	<p>Look for patterns, time of day/Sundowning Common triggers include:</p> <ul style="list-style-type: none"> • Boredom • Lack of physical activity • Searching for familiar/home • Dietary factors: sugar/caffeine • Medical factors: pain/constipation • Psychiatric issues: anxiety/mania
CREATE (TREATMENT)	<p>EMPLOY APPROPRIATE BEHAVIORAL AND SAFETY STRATEGIES. IF BEHAVIORAL INTERVENTIONS DO NOT RESOLVE BEHAVIORS: MEDICATION MAY BE NEEDED Mania - may need pharmacologic treatment: anti psychotics or mood stabilizers*</p>
EVALUATE (AND RE-EVALUATE)	<p>If wandering persists, look for other underlying causes</p> <ul style="list-style-type: none"> • *If patient stable 3-6 months, and psychotropic medication has been required, initiate a cautious incremental reduction and monitor patient closely • If intervention not effective or if patient or caregiver are in danger, consider referring to neurologist or psychiatrist

THE ALZHEIMER'S PROJECT

Caring for the Caregiver

When treating individuals with dementia, the clinician is really treating both the patient and the family members who are primarily responsible for the individual's care. Therefore, it is important to identify key signals that the caregivers may need more assessment, support, and both medical and psychological treatment. It is good to know who the caregivers are, what are the impacts of caregiving, and what steps can be used to support caregivers.

Caring for Dementia Means Caring for the Caregiver

The best care can be provided by caregivers who are rested, and who take the time for self-care, similar to the analogy that on a plane, "put your own oxygen mask on first." The patient's continued health and well-being depends on a family caregiver. That person must be willing and able to handle the patient's complex health, financial, legal, and social needs. With care for an individual with dementia, the job can continue for months, or more commonly years.

Who Are the Caregivers?⁴

According to the 2021 Alzheimer's Disease Facts and Figures report (alz.org/facts) there were over one million caregivers in California alone in 2020. Unpaid caregivers are providing an increasing proportion of the care needed, increasing by more than 20% since 2009.

The report details the demographics of family caregivers:

- 67% women, providing 21 hours or more per week; 33% are daughters,
- 30% age 65 or older,
- 60% are married or living with a partner or in a long-term relationship,
- Over 50% are providing assistance to a parent or in-law,

- 66% are White, 10% Black, 8% Hispanic, 5% Asian American nationally.

Female caregivers may experience slightly higher levels of burden, impaired mood, depression and impaired health than caregivers who are men, with evidence suggesting that these differences arise because female caregivers tend to spend more time caregiving, assume more caregiving tasks, and care for someone with more cognitive, functional and/or behavioral problems. Of dementia caregivers who indicated a need for individual counseling or respite care, the large majority were women (individual counseling, 85%, and respite care, 84%).

Racial disparities of Alzheimer's disease and related dementias (ADRD) mirror the disparities of other chronic diseases including hypertension, diabetes, and COPD. Older Black and Hispanic Americans are disproportionately more likely than older White Americans to have Alzheimer's or other dementias.

Data indicates prevalence rates among racial/ethnic adults 65 years of age and older at:

- 18.6% of Blacks
- 14% of Hispanics
- 10% of White older adults.

A higher proportion of lower-income individuals and people of color are cared for at home rather than in congregate settings; the demographic composition of family caregivers is also more prevalent in the African American, Hispanic/Latino, and other communities of color. The Alzheimer's Association study shows that Black caregivers are 69% less likely to use respite services when compared with White caregivers. Hispanic, Black, and Asian American dementia caregivers indicate greater care demands, less outside help/ formal service use, and greater depression when compared with White caregivers .

Three of the main reasons caregivers provide assistance to a person with ADRD are: (1) the desire to keep a family member or friend at home (65%), (2) proximity

⁴ 2021 Alzheimer's Disease Facts and Figures report (alz.org/facts)

to the person with dementia (48%), and (3) the caregiver's perceived obligation to the person with dementia (38%). Caregivers often indicate love and a sense of duty and obligation when describing what motivates them to assume care responsibilities for a relative or friend living with dementia. As those afflicted with dementia can live with the disease for four to 20 years, the slow, insidious and uncertain progression of the disease can take a substantial toll on caregivers.

Black caregivers are more likely than White caregivers to report positive aspects of caregiving. The report found that Black dementia caregivers indicate slightly higher psychological well-being than White dementia caregivers. Hispanic dementia caregivers, however, reported slightly lower physical well-being than White dementia caregivers. Support from family and friends is associated with better self-rated health for Black dementia caregivers, but not for White or Hispanic caregivers. A more positive perceived relationship between the caregiver and person with dementia was associated with better self-rated health among Black and White caregivers.

Health and Economic Impacts of Alzheimer's Caregiving

Caring for a person with Alzheimer's or another dementia poses special challenges. For example, people in the moderate to severe stages of Alzheimer's dementia experience losses in judgment, orientation, and the ability to understand and communicate effectively. Family caregivers must often help people with Alzheimer's manage these issues. The personality and behavior of a person with Alzheimer's are often affected as well, and these changes are among the most challenging for family caregivers. Individuals with ADRD also require increasing levels of supervision and personal care as the disease progresses. As the person with dementia's symptoms worsen, caregivers can experience increased emotional stress and depression; new or exacerbated health problems; and depleted income and finances due in part to

disruptions in employment and paying for health care or other services for themselves and people living with dementia.

Caregiver Emotional and Social Well-Being

The intimacy, shared experiences and memories that are often part of the relationship between a caregiver and person living with dementia may be threatened due to the memory loss, functional impairment and psychiatric/behavioral disturbances that can accompany the progression of ADRD. Almost half of caregivers of people with dementia indicated that providing help to someone with cognitive impairment was very rewarding. Although caregivers report positive feelings about caregiving, such as family togetherness and the satisfaction of helping others, they also frequently report higher levels of stress. It is important to stress to caregivers the importance of self-care to meet their own emotional and social needs.

(see Caregiver Tip sheet)

Burden and Stress

- Twice as many caregivers of those with dementia indicate substantial emotional, financial and physical difficulties as caregivers of people without dementia.
- 59% of family caregivers rated the emotional stress of caregiving as high or very high.
- Spousal dementia caregivers are more likely than non-spousal caregivers to experience increased burden over time, particularly when the loved one experiences behavioral changes and decreased functional ability.

Depression and Mental Health

Caregivers of people with dementia were significantly (30% to 40%) more likely to experience depression and anxiety than non-caregivers.

- Dementia caregivers also indicate more depressive symptoms than non-dementia caregivers.
- Caregivers of spouses with dementia had two-and-a-half times higher odds of having depression than

caregivers of people with dementia who were not spouses.

- The prevalence of anxiety among dementia caregivers is 44%, which is higher than among caregivers of people with stroke (31%).
- Increased depressive symptoms among caregivers over time are linked to more frequent doctor visits, increased outpatient tests and procedures, and greater use of over-the-counter and prescription medications.

Strain and Stress of Care

- Caregivers of people with ADRD were twice as likely as caregivers of individuals without dementia (22% compared with 11%) to report that completing medical/nursing-related tasks (for example, injections, tube feedings and catheter/colostomy care) was difficult.
- Dementia caregivers often lack the information or resources necessary to manage complex medication regimens.
- More than half of women with children under age 18 felt that caregiving for someone with dementia was more challenging than caring for children.
- 59% of caregivers felt they were “on duty” 24 hours a day, and many felt that caregiving during this time was extremely stressful.
- 72% of family caregivers experienced relief when the person with Alzheimer’s or another dementia died.

Caregiver Physical Health and Health Conditions

For some caregivers, the demands of caregiving may cause declines in their own health. Evidence suggests that the stress of providing dementia care increases caregivers’ susceptibility to disease and health complications.

- The distress associated with caregiving has been shown to negatively influence the quality of family caregivers’ sleep and caregivers are estimated to lose between 2.4 hours and 3.5 hours of sleep a week.
- Many caregivers may contend with health challenges of their own.
- Caregivers indicate lower health-related quality of life than non-caregivers and are more likely than non-caregivers or other caregivers to report that their health is fair or poor.
- Dementia caregivers who provided care to spouses were much more likely (41% increased odds) than other spousal caregivers of similar age to become increasingly frail during the time between becoming a caregiver and their spouse’s death.
- On a positive note, caregiving tasks may have the positive effect of keeping older caregivers more physically active than non-caregivers.

Mortality

Studies of how the health of people with dementia affects their caregivers’ risk of dying have had mixed findings:

- Caregivers who perceive higher strain due to care responsibilities were at higher risk for death than caregivers who perceive little or no strain.
- There is the possibility that individuals who assume dementia care roles do so in part because their initial health allows them to do so.
- 18% of spousal caregivers die before their partners with dementia.

Steps to Support Caregivers

1. Understand the multitude of impacts borne by caregivers.
2. Include caregivers as a member of the care team by identifying who they are, including them in appointments and conversations with the patient, and documenting their presence at visits and contact information in the patient's medical record.
3. Utilize a care team approach with social workers, nurse practitioners and other members of your office staff. Make referrals to palliative care teams as appropriate.
4. Assess and address the caregiver's physical and mental health, well-being, capacity and willingness to be a caregiver, and any unmet needs.
5. Be familiar with care options, system supports and community resources, and address caregiver needs via referral to appropriate services, including medical consultation, disease education resources, and online and community resources.
6. Create care plans for both patient and caregiver that are matched to their needs and reflect goals of care and advance care planning.
7. Train caregivers on behaviors as a form of communication, particularly as the patient's ability to communicate verbally diminishes.
8. Add information to EHR to track progress and to make use of appropriate billing codes (see page 48)

Appropriate Interventions Through Stages of the Disease

The goal of interventions is to improve the health and well-being of dementia caregivers by relieving the negative aspects of caregiving. Some also aim to delay admission of the person with dementia to long-term care facilities by providing caregivers with skills and resources (emotional, social, psychological and/or technological) to continue helping their relatives or friends at home. Specific approaches used in various interventions include:

- Psychoeducational approaches – caregivers learning about disease and caregiving,
- Assistance/education on dementia-related symptoms,
- Case management,
- Support groups and other social supports,
- Respite,
- Counseling,
- Self-care – exercise, personal care, nutrition,
- Consideration of medication.

If caregiver needs are unmet, chances are much higher that your patient's needs will be unmet as well. Community resources, as well as resources available through the provider's health system should be recommended. *See the Resource listing at end of the booklet.*

Assessing Family Caregivers

As a health care professional, you assess patients all the time. But you may not routinely assess a patient's family caregiver, especially if the caregiver is a patient of another clinician. When treating individuals with dementia, the clinician should be treating both the patient and the family members who are primarily responsible for the individual's care. Therefore, it is important to identify key signals that the caregivers may need more assessment, support, and both medical and psychological treatment. The primary care physician is encouraged to utilize the clinical team to conduct caregiver assessments.

Caregiver assessment is a tool to help identify strengths and limitations and to develop a realistic plan for the next stage of care. The goal is twofold: (1) to ensure that the patient's health and well-being are maintained and enhanced; and (2) to ensure that the caregiver's capacities and needs are considered and addressed in a care plan, and that the caregiver's capacities and needs are not exceeded by the patient's condition.

Next Step in Care (<https://www.nextstepincare.org>) has created a guide as an introduction to caregiver assessment in hospitals, nursing homes, and home health agencies. Although these settings are different, the guide gives some basic information and suggestions. These are the questions addressed:

- Who is a family caregiver?
- What is caregiver assessment and why is it important?
- Who should do it, when, and how?
- What should it cover?
- How should the assessment be used?

As a first step in caregiver assessment, it is essential to determine who provides and/or manages that care. Even when there is a designated family member who receives medical updates and communicates to the rest of the family, that person may not provide the hands-on care. One way to identify the main family caregiver

is to ask the patient, if he or she can respond, "Who helps you at home?" or "Whom do you rely on most for help at home?" If the patient cannot respond, then ask the family member who seems to be most involved if he or she lives with the patient and provides care at home. Instead of asking, "Are you a caregiver?" it is better to ask, "What do you do at home for your family member? Do you do this all the time? Is there anyone who helps you?"

What is the caregiver assessment?

According to the National Center on Caregiving at Family Caregiver Alliance, Caregiver Assessment is the process of gathering information to identify problems, needs, resources and strengths of the family caregiver aligned with the caregiver's perspective and culture. The assessment is focused on the caregiver rather than the individual with dementia and seeks to maintain the caregiver's own health and well-being.⁵

For family caregivers, an assessment is a chance to talk about their own lives for perhaps the first time in any encounter with the patient's health care team. They can express concerns about their own abilities to provide certain kinds of care, and the realities of their own situations. In health care settings, assessments will necessarily be brief but they can raise questions that the family caregiver can discuss further with others and can suggest types of resources that may be available and helpful. Some clinicians may be reluctant to ask questions about the kinds of help that a caregiver may need, because they cannot fill those gaps, but referral to community resources can be very helpful. But most caregivers are grateful for any suggestions and for the attention being paid to them.

Who should do a caregiver assessment, when, and how?

The primary care physician is encouraged to utilize the clinical team to conduct caregiver assessments. If a social worker is available to the practice, that person may be best suited. If the patient qualifies for home health care services, the home health agency

can provide a social work evaluation in the home. A nurse, nurse practitioner, or the rooming staff medical assistant may be able to initiate the assessment.

There are a number of self-assessment tools (see Instruments at end of section) that may be sent to the caregiver to complete prior to the patient's appointment, and bring to the appointment, similar to the use of the informant survey (AD8) to assess changes in behaviors in the individual with dementia. More important than the professional status of the assessors are their attitudes and ability to relate to the caregiver in a nonjudgmental and thoughtful way.

Assessments should be introduced as – and should be – a way to acknowledge the family caregiver's perspective, not as a test and certainly not as a guilt-inducing technique. The assessor should have good communication skills, including the ability to listen attentively, probe for clarifications, and respect diversity in all its many forms. If the caregiver does not speak English, the assessment should be done by a trained interpreter.

If possible, the assessment should be completed outside the presence of the individual with dementia, as the caregiver may not feel comfortable talking about their own needs or issues in front of their loved one. Potentially a clinical staff member could perform the assessment while the clinician is examining the patient. If upon a cursory assessment the clinician notes significant signs of stress, anxiety or depression, it would be helpful to request a separate appointment with the caregiver to provide adequate time for assessment and treatment or make a dedicated referral to the caregiver's primary care physician with direct communication to that practitioner.

What should the assessment cover?

There are a variety of caregiver assessment tools available; most, however, were developed for use in community-based agencies, not in health care settings. Using those assessment tools as a framework, some basic questions should include:

- The caregiver's background, including age, education, employment, other family responsibilities, living arrangements.
- The caregiver's perception of the care recipient's health and functional status.
- Length of time the caregiver has been providing care; if this is a new event, what the caregiver worries most about in providing care.
- Values and preferences about caregiving ("do it all myself,"; "can't deal with needles or incontinence,"; "I can't take Mom to my home because there just isn't room for another person").
- Caregiver's health status, including any limitations relevant to caregiving.
- Impact of caregiving on emotional status, finances, other family members.
- Knowledge, skills, and abilities to perform necessary caregiving tasks.
- Support systems available to reduce social isolation.
- Resources used or interested in accessing.

How should the assessment be used?

In introducing the assessment process to the family caregiver, the assessor should clarify the goals of the assessment and make it clear that all information (unless specified by the caregiver) will be shared with the health care team in order to develop a care plan. Caregivers should understand that a summary of the assessment may be documented in the medical record and perhaps shared with other healthcare professionals. Thus, if there is information that the caregiver does not want shared, this should be made clear to the person conducting the assessment. Family caregivers should be assured that the assessment will not be shared with the patient or other family members, unless the caregiver authorizes release of the information. Also, the caregiver should be informed that the assessor is a mandated reporter of suspected elder abuse or neglect, and in the event there is such a suspicion, confidentiality cannot be maintained.

The assessor should also summarize the conversation, so that the family caregiver feels that their concerns have been heard. The assessor can emphasize the positives first, and then list the areas where some questions have been raised and suggest a process for following up. The family caregiver can also be given a copy of one of the Self-Assessment tools for future use.

Family caregiver assessments are important tools to help obtain critical information about the person who will be responsible for patient care. Although they are being widely used in community-based social service settings, they are a relatively new tool in health care settings. In addition to providing information in a systematic way, assessments recognize the importance of family caregivers as direct care providers and managers, and affords them the opportunity to

self-identify as a caregiver and take stock of their strengths, limitations, and needs. To be effective, however, caregiver assessments must be undertaken by professionals with good communication and relationship-building skills.

The Zarit Burden Interview (ZBI-12) is included in these Guidelines and may be helpful in assessing caregiver burden and stress. There are also caregiver-information handouts available at <https://ChampionsforHealth.org/alzheimers> you may want to have on hand for family caregivers. Many of the dementia-specific organizations also provide valuable resources to improve the quality of life of caregivers.

5 (National Center on Caregiving at Family Caregiver Alliance, "Caregivers Count Too! A Toolkit to Help Practitioners Assess the Needs of Family Caregivers, June 2006)



Annual Wellness Visit

For the Medicare Annual Wellness Visits, the codes are the following:

G0438 Annual wellness visit; includes a personalized prevention plan of service, Initial visit.

G0439 Annual wellness visit; includes a personalized prevention plan of service, subsequent visit.

When you furnish a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service along with the AWWV, Medicare may pay for the additional service. Report the additional Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body member.

Cognitive Examination

Medicare established a new code in 2018 for services aimed at improving detection, diagnosis, and care planning and coordination for patients with Alzheimer's disease and related dementias. CPT code 99483, which supersedes the older code G0505, provides reimbursement to physicians and other eligible billing practitioners for a comprehensive clinical visit that results in a written care plan.

Code 99483 requires an independent historian; a multidimensional assessment that includes cognition, function, and safety; evaluation of neuropsychiatric and behavioral symptoms; review and reconciliation of medications; and assessment of the needs of the patient's caregiver. Eligible practitioners must provide documentation that supports a moderate-to-high level of complexity in medical decision making, as defined by E/M guidelines (with application as appropriate of the usual "incident-to" rules, consistent with other E/M services) The provider must also document the detailed care plan developed as a result of each required element covered by 99483. Typically, 50 minutes are spent face to face with the patient and/or family or caregiver.

The nine assessment elements of 99483 can be evaluated within the care planning visit or in one or more visits that precede it, using appropriate billing codes (most often an E/M code). Patients with complex medical, behavioral, psychosocial and/or caregiving needs may require a series of assessment visits, while those with well-defined or less complex problems may be fully assessed during the care plan visit. Results of assessments conducted prior to the care plan visit are allowed in care planning documentation provided they remain valid or are updated with any changes at the time of care planning. A single physician or other qualified health care professional should not report 99483 more than once every 180 days. (See the CPT 2018 manual for full details.)

Ongoing Care Management

For care management bill the regular E&M codes:

99203-99205 (New patient)

99212-99215 (Established patients)

For any additional time spent with the patient during an E&M visit you can bill a prolonged code. 99417 (For commercial payers) – Prolonged office or other outpatient evaluation and management services beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time. G2212 (For Medicare billing).

Advance Care Planning

CPT 99497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

CPT 99498: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such

forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes. (List separately in addition to code for primary procedure)

You must report a diagnosis code when submitting a claim for ACP as an optional element of an AWW. Since you are not required to document a specific diagnosis code for ACP as an optional element of an AWW, you may choose any diagnosis code consistent with a beneficiary's exam.

Medicare waives both the coinsurance and the Medicare Part B deductible for ACP when it is:

- Provided on the same day as the covered AWW,
- Furnished by the same provider as the covered AWW,
- Billed with modifier -33 (Preventive Service),
- Billed on the same claim as the AWW.

The deductible and coinsurance for ACP are waived only once per year, when it is billed with the AWW. If the AWW billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP.

NOTE: The deductible and coinsurance apply when ACP is provided outside the covered AWW.

Footnotes for FDA approved medications from pages 17-18:

1. Choosing Wisely. Don't prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects [Internet]. Philadelphia: ABIM Foundation; 2014 [updated 2015 Apr 23; cited 2020 Jun 9]. Available at: <https://www.choosingwisely.org/clinician-lists/american-geriatrics-society-cholinesterase-inhibitors-for-dementia/>
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Also see References page 54.

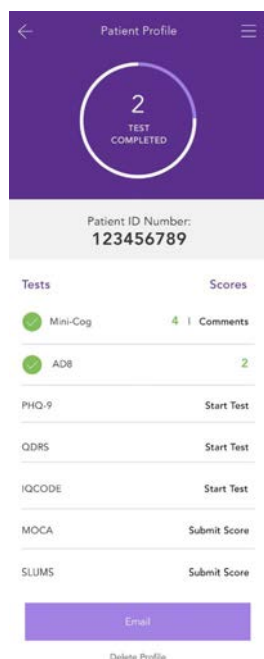
Continuing Medical Education

Primary care practitioners can take advantage of ongoing professional education on-demand webinars. The courses, provided in partnership with The Doctors Company, are available free of charge and are approved for AMA PRA Category 1 Credits™. The courses are meant to act as training tools, that can be taken at your own convenience in approximately 15-minute segments. You are encouraged to revisit as needed. All courses were edited and recertified in 2021.

Mobile Application for Screening, Diagnosis and Management

The information, algorithms and instruments included in these guidelines are also available on a mobile application, AlzDxRx, available for free in San Diego for both iOS and Android phones. The app assists physicians to walk through screening and evaluation of patients with cognitive decline, as well as assess caregiver stress, while maintaining eye-to-eye contact.

Access scoring instruments: MiniCog, AD8, PHQ-9, QDRS, IQCODE, MOCA, SLUMS, and ZBI12. Patient identified scores can be emailed for ease in adding to EHR.



Website Resources

Resources for clinicians are available and updated regularly at: [ChampionsforHealth.org/alzheimers](https://championsforhealth.org/alzheimers). Resources also include patient and caregiver handouts and exam room posters to encourage individuals to speak with their practitioner should they have concerns of memory loss.

The following pages include:

References and links for all sections

Screening Instruments

- MiniCog
- AD8
- ADL

Evaluation Instruments

- QDRS
- IQCODE
- MOCA
- qMCI
- SLUMS
- PHQ-9
- Geriatric Depression Scale
- Common scales for assessment of BPSD
- ZBI-12

Resources for Caregivers

- Preparing for Your Doctor's Visit
- Information and Resources for Caregivers
- Tips for Caregivers
- Effective Communication

All information and resources can be found at [ChampionsforHealth.org/Alzheimers](https://championsforhealth.org/Alzheimers). Information is regularly updated.

Some useful general informational resources include:

Alzheimer's Association <http://alz.org>

Alzheimer's San Diego <http://alzsd.org>

Alzheimer's Disease Education and Referral (ADEAR) <https://www.nia.nih.gov/alzheimers>

Alzheimer's Drug Discovery Foundation (ADDF) information about risk factors. <https://www.alzdiscovery.org>

California Alzheimer's Disease Centers, California Department of Public Health. Assessment of Cognitive Complaints Toolkit. <http://www.fresno.ucsf.edu/wp-content/uploads/2018/09/ACCT-AD-Toolkit.pdf>

Gerontological Society of America, KAER Toolkit: 4-Step Process to Detecting Cognitive Impairment and Earlier Diagnosis of Dementia. <https://www.geron.org/programs-services/alliances-and-multi-stakeholder-collaborations/brain-health-cognitive-impairment-and-dementia-2>

American Academy of Neurology <https://aan.com>

Clinical trials:

[Clinicaltrials.gov](http://clinicaltrials.gov)

<https://clinicaltrials.gov/ct2/results?cond=dementia&term=&cntry=&state=&city=&dist=>

Alzheimer Association TrialMatch <https://www.alz.org/alzheimers-dementia/research-progress/clinical-trials/about-clinical-trials>

For non-AD disorders:

Lewy Body Dementia Association <http://www.LBDA.org>

Association for Frontotemporal Degeneration (AFTD) <http://www.theaftd.org>

Screening & Evaluation Instruments

qMCI: <http://www.qmci.ie>

Comparison of the Quick Mild Cognitive Impairment (Qmci) screen to the Montreal Cognitive Assessment (MoCA) in an Australian geriatrics clinic - PubMed <https://pubmed.ncbi.nlm.nih.gov/27427212/>

AD8: <https://www.alz.org/media/Documents/ad8-dementia-screening.pdf>

Mini-Cog: http://mini-cog.com/wp-content/uploads/2018/03/Standardized-English-Mini-Cog-1-19-16-EN_v1-low-1.pdf

MOCA In English and other languages: <https://www.mocatest.org>

PHQ-9 in English and other languages: <https://www.communitycarenc.org/provider-tools>

SLUMS Examination in English and other languages: <https://www.elderguru.com/slums-dementia-test-available-in-various-languages/>

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Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.¹⁻³ For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

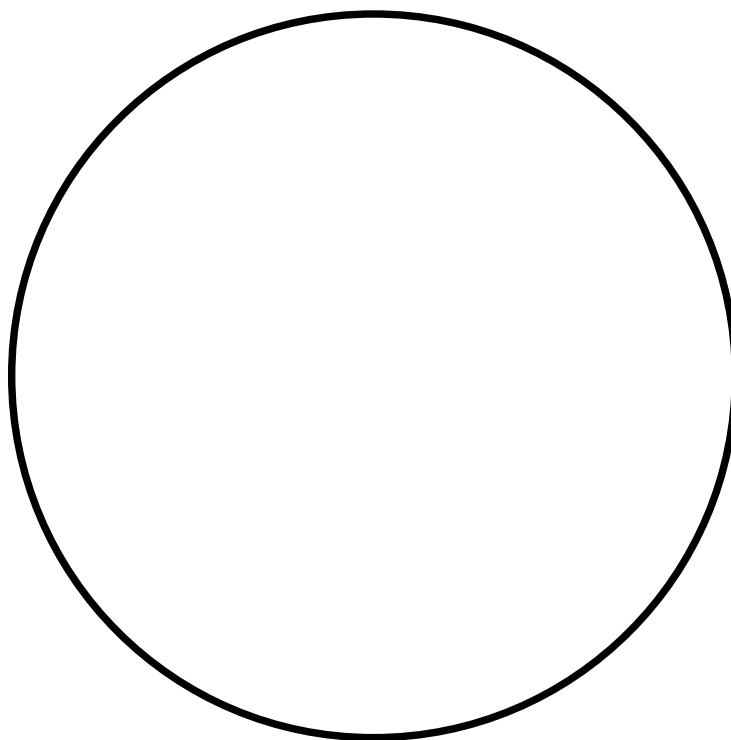
Word List Version: _____ Person's Answers: _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID: _____ Date: _____



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MINI-COG™ -Spanish

1) OBTENGA LA ATENCIÓN DEL PARTICIPANTE, Y DIGA:

“Le voy a decir tres palabras que quiero que usted recuerde ahora y más tarde. Las palabras son

Manzana Amanecer Silla

Por favor, dígamelas ahora.”

Intento 1 _____

Intento 2
(administre sólo si las 3 palabras no fueron repetidas en el Intento 1. Diga **“Las palabras son Manzana, Amanecer, Silla. Por favor, dígamelas ahora”**)

Intento 3
(administre sólo si las 3 palabras no fueron repetidas en el Intento 2. Diga **“Las palabras son Manzana, Amanecer, Silla. Por favor, dígamelas ahora”**)

(Indique con una marca de verificación [✓] cada palabra que es repetida correctamente. Dele 3 intentos para repetir las palabras al participante. Si es incapaz de repetir las palabras después de 3 intentos, continúe con el siguiente ítem.)

2) Dele al participante la Página 2 de este formulario y un lápiz/lapicero. DIGA LAS SIGUIENTES FRASES EN EL ORDEN CORRESPONDIENTE:

“Por favor, dibuje un reloj en este espacio. Comience dibujando un círculo grande.” (Cuando esto haya sido completado, diga)

“Coloque todos los números en el círculo.” (Cuando esto haya sido completado, diga) **“Ahora coloque las manecillas del reloj para que marquen las 11 y 10.”** Si el participante no ha terminado de dibujar el reloj en 3 minutos, suspenda este ítem y pídale al participante que le diga las tres palabras que le pidió que recordara antes.

3) DIGA: **“¿Cuáles fueron las tres palabras que le pedí que recordara?”**

_____ (Puntúe 1 por cada una) Puntaje de las Palabras ☐

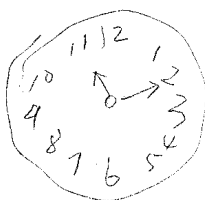
Puntúe el reloj (según el formulario de Puntaje del Reloj):
Reloj Normal 2 puntos Puntaje del Reloj ☐
Reloj Alterado 0 puntos

Puntaje Total = Puntaje de Palabras más Puntaje del Reloj ☐ **0, 1, o 2 posible trastorno cognitivo;
3, 4, o 5 indica que no hay trastorno cognitivo**

Mini-Cog™, Derecho de autor S Borson. Permitido para uso educacional en el "AFA National Memory Screening Day" en el año 2012. No se puede modificar o usar para otro propósito sin permiso del autor (soob@uw.edu). Todos los derechos están reservados.

PUNTAJE DEL DIBUJO DEL RELOJ

RELOJ NORMAL



UN RELOJ NORMAL CONTIENE TODOS LOS SIGUIENTES ELEMENTOS:

Todos los números 1-12, cada uno solo una vez, están presentes en el orden y dirección correctas dentro del círculo. Dos manecillas están presentes, una apuntando al 11 y la otra al 2.

CUALQUIER RELOJ AL QUE LE FALTE ALGUNO DE ESTOS ELEMENTO SE CONSIDERA ANORMAL. SI EL PARTICIPANTE SE REÚSA A DIBUJAR EL RELOJ, ENTONCES ÉSTE SE CONSIDERA ANORMAL.

ALGUNOS EJEMPLOS DE RELOJES ANORMALES (EXISTEN MUCHAS OTRAS CLASES)



Agujas Incorrectas



Faltan algunos números

AD8 Dementia Screening Interview

Patient ID#: _____

CS ID#: _____

Date: _____

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	N/A, Don't know
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)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005;65:559-564

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The AD8 Administration and Scoring Guidelines

A spontaneous self-correction is allowed for all responses without counting as an error.

The questions are given to the respondent on a clipboard for self-administration or can be read aloud to the respondent either in person or over the phone. It is preferable to administer the AD8 to an informant, if available. If an informant is not available, the AD8 may be administered to the patient.

When administered to an informant, specifically ask the respondent to rate change in the patient.

When administered to the patient, specifically ask the patient to rate changes in his/her ability for each of the items, **without** attributing causality.

If read aloud to the respondent, it is important for the clinician to carefully read the phrase as worded and give emphasis to note changes due to cognitive problems (not physical problems). There should be a one second delay between individual items.

No timeframe for change is required.

The final score is a sum of the number items marked “Yes, A change”.

Interpretation of the AD8 (Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, *Neurology* 2005;65:559-564)

A screening test in itself is insufficient to diagnose a dementing disorder. The AD8 is, however, quite sensitive to detecting early cognitive changes associated many common dementing illness including Alzheimer disease, vascular dementia, Lewy body dementia and frontotemporal dementia.

Scores in the impaired range (see below) indicate a need for further assessment. Scores in the “normal” range suggest that a dementing disorder is unlikely, but a very early disease process cannot be ruled out. More advanced assessment may be warranted in cases where other objective evidence of impairment exists.

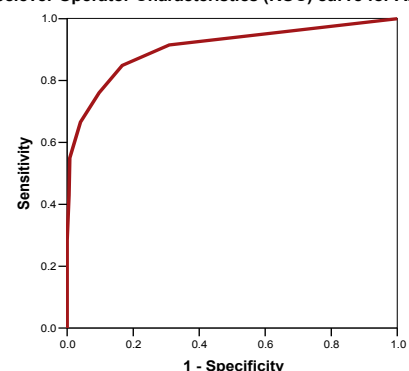
Based on clinical research findings from 995 individuals included in the development and validation samples, the following cut points are provided:

- 0 – 1: Normal cognition
- 2 or greater: Cognitive impairment is likely to be present

Administered to either the informant (preferable) or the patient, the AD8 has the following properties:

- Sensitivity > 84%
- Specificity > 80%
- Positive Predictive Value > 85%
- Negative Predictive Value > 70%
- Area under the Curve: 0.908; 95%CI: 0.888-0.925

Receiver Operator Characteristics (ROC) curve for AD8



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AD8 Dementia Screening Interview

Patient ID#: _____

CS ID#: _____

Date: _____

<p>Recuerde: "sí. Hay cambios." significa que ha habido un cambio en los últimos años debido a problemas cognitivos (pensamiento y memoria).</p>	<p>SÍ. Hay cambios 1 punto</p>	<p>NO. No hay cambios 0 punto</p>	<p>No aplicable. No sé.</p>
1. Problemas de juicio (ejemplo: compra regalos inadecuados, ha sido estafado/a, toma malas decisiones en lo económico)			
2. Menor interés en realizar actividades o sus pasatiempos			
3. Repite las preguntas, historias			
4. Tiene dificultad para aprender a usar instrumentos tecnológicos, electrodomésticos (como el control remoto TV, computador, microondas, video grabadora)			
5. Olvida el mes o año			
6. Tiene dificultad en el manejo de asuntos financieros complejos (pagar las cuentas, llevar la chequera, pago de impuestos)			
7. Tiene dificultad para acordarse de los compromisos (citas al doctor etc.)			
8. Problema persistente de memoria y pensamiento (no ocasional)			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005;65:559-564
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ant interview to detect dementia, Neurology 2005;65:559-564
Alzheimer's Disease Research Center, Washington University, St. Louis, Missouri.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (IADL)

M.P. Lawton & E.M. Brody

A. Ability to use telephone

- | | |
|---|---|
| 1. Operates telephone on own initiative; looks up and dials numbers, etc. | 1 |
| 2. Dials a few well-known numbers | 1 |
| 3. Answers telephone but does not dial | 1 |
| 4. Does not use telephone at all. | 0 |

B. Shopping

- | | |
|---|---|
| 1. Takes care of all shopping needs independently | 1 |
| 2. Shops independently for small purchases | 0 |
| 3. Needs to be accompanied on any shopping trip. | 0 |
| 4. Completely unable to shop. | 0 |

C. Food Preparation

- | | |
|--|---|
| 1. Plans, prepares and serves adequate meals independently | 1 |
| 2. Prepares adequate meals if supplied with ingredients | 0 |
| 3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet. | 0 |
| 4. Needs to have meals prepared and served. | 0 |

D. Housekeeping

- | | |
|--|---|
| 1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help") | 1 |
| 2. Performs light daily tasks such as dish-washing, bed making | 1 |
| 3. Performs light daily tasks but cannot maintain acceptable level of cleanliness. | 1 |
| 4. Needs help with all home maintenance tasks. | 1 |
| 5. Does not participate in any housekeeping tasks. | 0 |

E. Laundry

- | | |
|---|---|
| 1. Does personal laundry completely | 1 |
| 2. Launders small items; rinses stockings, etc. | 1 |
| 3. All laundry must be done by others. | 0 |

F. Mode of Transportation

- | | |
|--|---|
| 1. Travels independently on public transportation or drives own car. | 1 |
| 2. Arranges own travel via taxi, but does not otherwise use public transportation. | 1 |
| 3. Travels on public transportation when accompanied by another. | 1 |
| 4. Travel limited to taxi or automobile with assistance of another. | 0 |
| 5. Does not travel at all. | 0 |

G. Responsibility for own medications

- | | |
|--|---|
| 1. Is responsible for taking medication in correct dosages at correct time. | 1 |
| 2. Takes responsibility if medication is prepared in advance in separate dosage. | 0 |
| 3. Is not capable of dispensing own medication. | 0 |

H. Ability to Handle Finances

- | | |
|---|---|
| 1. Manages financial matters independently (budgets, writes checks, pays rent, bills goes to bank), collects and keeps track of income. | 1 |
| 2. Manages day-to-day purchases, but needs help with banking, major purchases, etc. | 1 |
| 3. Incapable if handling money. | 0 |

Source: Lawton, M.P., and Brody, E.M. "Assessment of older people: Self-maintaining and instrumental activities of daily living." *Gerontologist* 9:179-186, (1969).

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The QDRS, Quick Dementia Rating System

1. Memory and recall

_____C

- 0 No obvious memory loss or inconsistent forgetfulness that does not interfere with function in everyday activities
- 0.5 Consistent mild forgetfulness or partial recollection of events that may interfere with performing everyday activities; repeats questions/statements, misplaces items, forgets appointments
- 1 Mild to moderate memory loss; more noticeable for recent events; interferes with performing everyday activities
- 2 Moderate to severe memory loss; only highly learned information remembered; new information rapidly forgotten
- 3 Severe memory loss, almost impossible to recall new information; long-term memory may be affected

2. Orientation

_____C

- 0 Fully oriented to person, place, and time nearly all the time
- 0.5 Slight difficulty in keeping track of time; may forget day or date more frequently than in the past
- 1 Mild to moderate difficulty in keeping track of time and sequence of events; forgets month or year; oriented to familiar places but gets confused outside familiar areas; gets lost or wanders
- 2 Moderate to severe difficulty, usually disoriented to time and place (familiar and unfamiliar); frequently dwells in past
- 3 Only oriented to their name, although may recognize family members

3. Decision making and problem-solving abilities

_____C

- 0 Solves everyday problems without difficulty; handles personal business and financial matters well; decision-making abilities consistent with past performance
- 0.5 Slight impairment or takes longer to solve problems; trouble with abstract concepts; decisions still sound
- 1 Moderate difficulty with handling problems and making decisions; defers many decisions to others; social judgment and behavior may be slightly impaired; loss of insight
- 2 Severely impaired in handling problems, making only simple personal decisions; social judgment and behavior often impaired; lacks insight
- 3 Unable to make decisions or solve problems; others make nearly all decisions for patient

4. Activities outside the home

_____B

- 0 Independent in function at the usual level of performance in profession, shopping, community and religious activities, volunteering, or social groups
- 0.5 Slight impairment in these activities compared with previous performance; slight change in driving skills; still able to handle emergency situations
- 1 Unable to function independently but still may attend and be engaged; appears “normal” to others; notable changes in driving skills; concern about ability to handle emergency situations
- 2 No pretense of independent function outside the home; appears well enough to be taken to activities outside the family home but generally needs to be accompanied
- 3 No independent function or activities; appear too ill to be taken to activities outside the home

5. Function at home and hobby activities

_____B

- 0 Chores at home, hobbies and personal interests are well maintained compared with past performance
- 0.5 Slight impairment or less interest in these activities; trouble operating appliances (particularly new purchases)
- 1 Mild but definite impairment in home and hobby function; more difficult chores or tasks abandoned; more complicated hobbies and interests given up
- 2 Only simple chores preserved, very restricted interest in hobbies which are poorly maintained
- 3 No meaningful function in household chores or with prior hobbies

6. Toileting and personal hygiene

____ **B**

- 0 Fully capable of self-care (dressing, grooming, washing, bathing, toileting)
- 0.5 Slight changes in abilities and attention to these activities
- 1 Needs prompting to complete these activities but may still complete independently
- 2 Requires some assistance in dressing, hygiene, keeping of personal items; occasionally incontinent
- 3 Requires significant help with personal care and hygiene; frequent incontinence

7. Behavior and personality changes

____ **B**

- 0 Socially appropriate behavior in public and private; no changes in personality
- 0.5 Questionable or very mild changes in behavior, personality, emotional control, appropriateness of choices
- 1 Mild changes in behavior or personality
- 2 Moderate behavior or personality changes, affects interactions with others; may be avoided by friends, neighbors, or distant relatives
- 3 Severe behavior or personality changes; making interactions with others often unpleasant or avoided

8. Language

____ **C**

- 0 No language difficulty or occasional word searching; reads and writes as in the past
- 0.5 Consistent mild word finding difficulties, using descriptive terms or takes longer to get point across, mild problems with comprehension, decreased conversation; may affect reading and writing
- 1 Moderate word finding difficulty in speech, cannot name objects, marked reduction in work production; reduced comprehension, conversation, writing, and/or reading
- 2 Moderate to severe impairments in speech production or comprehension; has difficulty in communicating thoughts to others; limited ability to read or write
- 3 Severe deficits in language and communication; little to no understandable speech is produced

9. Mood

____ **B**

- 0 No changes in mood, interest, or motivation level
- 0.5 Occasional sadness, depression, anxiety, nervousness, or loss of interest/motivation
- 1 Daily mild issues with sadness, depression, anxiety, nervousness, or loss of interest/motivation
- 2 Moderate issues with sadness, depression, anxiety, nervousness, or loss of interest/motivation
- 3 Severe issues with sadness, depression, anxiety, nervousness, or loss of interest/motivation

10. Attention and concentration

____ **B**

- 0 Normal attention, concentration, and interaction with his or her environment and surroundings
- 0.5 Mild problems with attention, concentration, and interaction with environment and surroundings, may appear drowsy during day
- 1 Moderate problems with attention and concentration, may have staring spells or spend time with eyes closed, increased daytime sleepiness
- 2 Significant portion of the day is spend sleeping, not paying attention to environment, when having a conversation may say things that are illogical or not consistent with topic
- 3 Limited to no ability to pay attention to external environment or surroundings

Cognitive subtotal (questions 1, 2, 3, 8) **Total of C Scores**

Behavioral subtotal (questions 4, 5, 6, 7, 9, 10) **Total of B Scores**

Total QDRS score

A total score of ≥ 2 suggests a problem causing limitations or issues, and may need a detailed workup. Please return this instrument to your physician.

Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) Short Form

Compared with 10 years ago how is this person at:

1. Remembering things about family and friends e.g. occupations, birthdays, addresses?	1 2 3 4 5
2. Remembering things that have happened recently?	1 2 3 4 5
3. Recalling conversations a few days later?	1 2 3 4 5
4. Remembering his/her address and telephone number?	1 2 3 4 5
5. Remembering what day and month it is?	1 2 3 4 5
6. Remembering where things are usually kept?	1 2 3 4 5
7. Remembering where to find things which have been put in a different place from usual?	1 2 3 4 5
8. Knowing how to work familiar machines around the house?	1 2 3 4 5
9. Learning to use a new gadget or machine around the house?	1 2 3 4 5
10. Learning new things in general?	1 2 3 4 5
11. Following a story in a book or on TV?	1 2 3 4 5
12. Making decisions on everyday matters?	1 2 3 4 5
13. Handling money for shopping?	1 2 3 4 5
14. Handling financial matters e.g. the pension, dealing with the bank?	1 2 3 4 5
15. Handling other everyday arithmetic problems e.g. knowing how much food to buy, knowing how long between visits from family or friends?	1 2 3 4 5
16. Using his/her intelligence to understand what's going on and to reason things through?	1 2 3 4 5
Total Score	

To score the IQCODE, add up the score for each question and divide by the number of questions. For the short IQCODE, divide by 16. The result is a score that ranges from 1 to 5. A score of 3 means that the subject is rated on average as 'no change'. A score of 4 means an average of 'a bit worse'. A score of 5 an average of 'much worse'. For the short IQCODE, a cutting point of 3.31/3.38 achieves a balance of sensitivity and specificity.



Nombre

Fecha

Unidad/Centro

Nº Historia

CRIBADO DE DEMENCIAS - TEST DEL INFORMADOR -

Población diana: Población informante clave de una persona con sospecha de deterioro cognitivo. Se trata de un test **autoadministrado**.

Instrucciones para el informante clave:

Recuerde, por favor, cómo era su familiar hace 5 ó 10 años y compare cómo es él en este momento. Conteste si ha habido algún cambio a lo largo de este tiempo en la capacidad de su familiar para cada uno de los aspectos que le preguntamos. Puntúe con los siguientes criterios:

	Ha mejorado mucho	Ha mejorado un poco	Casi sin cambios	Ha empeorado un poco	Ha empeorado mucho
ITEMS	1	2	3	4	5
Capacidad para reconocer las caras de sus personas más íntimas (parientes, amigos)					
Capacidad para recordar los nombres de estas mismas personas					
Recordar las cosas de esas personas (dónde viven, de qué viven, cuándo es su cumpleaños)					
Recordar cosas que han ocurrido recientemente, en los últimos 2 o 3 meses (noticias, cosas suyas o de sus familiares)					
Recordar lo que habló en una conversación unos días antes					
Olvidar lo que se ha dicho unos minutos antes, pararse a la mitad de una frase y no saber lo que iba a decir, repetir lo que ha dicho antes					
Recordar su propia dirección o número de teléfono					
Recordar la fecha en que vive					
Conocer el sitio exacto de los armarios de su casa y dónde se guardan las cosas					
Saber dónde se pone una cosa que se ha encontrado descolocada					
Adaptarse a la situación cuando su rutina diaria se ve alterada (ir de visita, en alguna celebración, de vacaciones)					
Saber manejar los aparatos de la casa (teléfono, coche, lavadora, máquina de afeitar, etc.)					
Capacidad para aprender a manejar un aparato nuevo (lavadora, tocadiscos, radio, secador de pelo, etc.)					

	Ha mejorado mucho	Ha mejorado un poco	Casi sin cambios	Ha empeorado un poco	Ha empeorado mucho
ITEMS	1	2	3	4	5
Recordar las cosas que han sucedido recientemente (en general)					
Aprender cosas nuevas (en general)					
Capacidad para recordar cosas que ocurrieron o que aprendió cuando era joven					
Comprender el significado de palabras poco corrientes (del periódico, televisión, conversación)					
Entender artículos de periódicos o revistas en las que está interesado					
Seguir una historia del libro, la prensa, el cine, la radio o la televisión					
Redactar cartas a parientes o amigos o cartas de negocios					
Recordar gentes y hechos históricos del pasado (guerra civil, república, etc.)					
Tomar decisiones tanto en cuestiones cotidianas (qué traje ponerse, qué comida preparar) como en asuntos a más largo plazo (dónde ir de vacaciones o invertir el dinero)					
Manejar asuntos financieros (cobrar la pensión, pagar la renta o los impuestos, tratar con el banco)					
Manejar dinero para la compra (cuánto dinero dar, calcular el cambio)					
Manejar otros problemas aritméticos cotidianos (tiempo entre visitas de parientes, cuánta comida comprar y preparar, especialmente si hay invitados)					
¿Cree que su inteligencia (en general) ha cambiado en algo durante los últimos 10 años?					
PUNTUACIÓN TOTAL					

Montreal Cognitive Assessment (MoCA)

Version 8.1

Administration and Scoring Instructions

The Montreal Cognitive Assessment (MoCA) was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. The MoCA may be administered by anyone who understands and follows the instructions, however, only a health professional with expertise in the cognitive field may interpret the results. Time to administer the MoCA is approximately 10 minutes. The total possible score is 30 points; a score of 26 or above is considered normal.

All instructions may be repeated once.

1. Alternating Trail Making:

Administration: The examiner instructs the subject: *"Please draw a line going from a number to a letter in ascending order. Begin here [point to (1)] and draw a line from 1 then to A then to 2 and so on. End here [point to (E)]."*

Scoring: One point is allocated if the subject successfully draws the following pattern: 1- A- 2- B- 3- C- 4- D- 5- E, without drawing any lines that cross. Any error that is not immediately self-corrected (meaning corrected before moving on to the Cube task) earns a score of 0. A point is not allocated if the subject draws a line to connect the end (E) to the beginning (1).

2. Visuoconstructional Skills (Cube):

Administration: The examiner gives the following instructions, pointing to the cube: *"Copy this drawing as accurately as you can."*

Scoring: One point is allocated for a correctly executed drawing.

- Drawing must be three-dimensional.
- All lines are drawn.
- All lines meet with little or no space.
- No line is added.
- Lines are relatively parallel and their length is similar (rectangular prisms are accepted).
- The cube's orientation in space must be preserved.

A point is not assigned if any of the above criteria is not met.

3. Visuoconstructional Skills (Clock):

Administration: The examiner must ensure that the subject does not look at his/her watch while performing the task and that no clocks are in sight. The examiner indicates the appropriate space and gives the following instructions: *"Draw a clock. Put in all the numbers and set the time to 10 past 11."*

Scoring: One point is allocated for each of the following three criteria:

- Contour (1 pt.): the clock contour must be drawn (either a circle or a square). Only minor distortions are acceptable (e.g., slight imperfection on closing the circle). If the numbers are arranged in a circular manner but the contour is not drawn the contour is scored as incorrect.
- Numbers (1 pt.): all clock numbers must be present with no additional numbers. Numbers must be in the correct order, upright and placed in the approximate quadrants on the clock face. Roman numerals are acceptable. The numbers must be arranged in a circular manner (even if the contour is a square). All numbers must either be placed inside or outside the clock contour. If the subject places some numbers inside the clock contour and some outside the clock contour, (s)he does not receive a point for Numbers.
- Hands (1 pt.): there must be two hands jointly indicating the correct time. The hour hand must be clearly shorter than the minute hand. Hands must be centered within the clock face with their junction close to the clock center.

4. Naming:

Administration: Beginning on the left, the examiner points to each figure and says: *“Tell me the name of this animal.”*

Scoring: One point is given for each of the following responses: (1) lion (2) rhinoceros or rhino (3) camel or dromedary.

5. Memory:

Administration: The examiner reads a list of five words at a rate of one per second, giving the following instructions: *“This is a memory test. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn’t matter in what order you say them.”* The examiner marks a check in the allocated space for each word the subject produces on this first trial. The examiner may not correct the subject if (s)he recalls a deformed word or a word that sounds like the target word. When the subject indicates that (s)he has finished (has recalled all words), or can recall no more words, the examiner reads the list a second time with the following instructions: *“I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time.”* The examiner puts a check in the allocated space for each word the subject recalls on the second trial. At the end of the second trial, the examiner informs the subject that (s)he will be asked to recall these words again by saying: *“I will ask you to recall those words again at the end of the test.”*

Scoring: No points are given for Trials One and Two.

6. Attention:

Forward Digit Span: Administration: The examiner gives the following instructions: *“I am going to say some numbers and when I am through, repeat them to me exactly as I said them.”* The examiner reads the five number sequence at a rate of one digit per second.

Backward Digit Span: Administration: The examiner gives the following instructions: *“Now I am going to say some more numbers, but when I am through you must repeat*

them to me in the backward order.” The examiner reads the three number sequence at a rate of one digit per second. If the subject repeats the sequence in the forward order, the examiner may not ask the subject to repeat the sequence in backward order at this point.

Scoring: One point is allocated for each sequence correctly repeated (N.B.: the correct response for the backward trial is 2-4-7).

Vigilance: Administration: The examiner reads the list of letters at a rate of one per second, after giving the following instructions: “*I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand.*”

Scoring: One point is allocated if there is zero to one error (an error is a tap on a wrong letter or a failure to tap on letter A).

Serial 7s: Administration: The examiner gives the following instructions: “*Now, I will ask you to count by subtracting 7 from 100, and then, keep subtracting 7 from your answer until I tell you to stop.*” The subject must perform a mental calculation, therefore, (s)he may not use his/her fingers nor a pencil and paper to execute the task. The examiner may not repeat the subject’s answers. If the subject asks what her/his last given answer was or what number (s)he must subtract from his/her answer, the examiner responds by repeating the instructions if not already done so.

Scoring: This item is scored out of 3 points. Give no (0) points for no correct subtractions, 1 point for one correct subtraction, 2 points for two or three correct subtractions, and 3 points if the subject successfully makes four or five correct subtractions. Each subtraction is evaluated independently; that is, if the subject responds with an incorrect number but continues to correctly subtract 7 from it, each correct subtraction is counted. For example, a subject may respond “92 – 85 – 78 – 71 – 64” where the “92” is incorrect, but all subsequent numbers are subtracted correctly. This is one error and the task would be given a score of 3.

7. Sentence repetition:

Administration: The examiner gives the following instructions: “*I am going to read you a sentence. Repeat it after me, exactly as I say it [pause]: **I only know that John is the one to help today.***” Following the response, say: “*Now I am going to read you another sentence. Repeat it after me, exactly as I say it [pause]: **The cat always hid under the couch when dogs were in the room.***”

Scoring: One point is allocated for each sentence correctly repeated. Repetitions must be exact. Be alert for omissions (e.g., omitting “only”), substitutions/additions (e.g., substituting “only” for “always”), grammar errors/altering plurals (e.g. “hides” for “hid”), etc.

8. Verbal fluency:

Administration: The examiner gives the following instructions: “*Now, I want you to tell me as many words as you can think of that begin with the letter F. I will tell you to stop after one minute. Proper nouns, numbers, and different forms of a verb are not permitted. Are you ready? [Pause] [Time for 60 sec.] Stop.*” If the subject names two consecutive

words that begin with another letter of the alphabet, the examiner repeats the target letter if the instructions have not yet been repeated.

Scoring: One point is allocated if the subject generates 11 words or more in 60 seconds. The examiner records the subject's responses in the margins or on the back of the test sheet.

9. **Abstraction:**

Administration: The examiner asks the subject to explain what each pair of words has in common, starting with the example: *"I will give you two words and I would like you to tell me to what category they belong to [pause]: an orange and a banana."* If the subject responds correctly the examiner replies: *"Yes, both items are part of the category Fruits."* If the subject answers in a concrete manner, the examiner gives one additional **prompt**: *"Tell me another category to which these items belong to."* If the subject does not give the appropriate response (*fruits*), the examiner says: *"Yes, and they also both belong to the category Fruits."* No additional instructions or clarifications are given. After the practice trial, the examiner says: *"Now, a train and a bicycle."* Following the response, the examiner administers the second trial by saying: *"Now, a ruler and a watch."* A **prompt** (one for the entire abstraction section) may be given if none was used during the example.

Scoring: Only the last two pairs are scored. One point is given for each pair correctly answered. The following responses are acceptable:

- train-bicycle = means of transportation, means of travelling, you take trips in both
- ruler-watch = measuring instruments, used to measure

The following responses are **not** acceptable:

- train-bicycle = they have wheels
- ruler-watch = they have numbers

10. **Delayed recall:**

Administration: The examiner gives the following instructions: *"I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember."* The examiner makes a check mark (✓) for each of the words correctly recalled spontaneously without any cues, in the allocated space.

Scoring: **One point is allocated for each word recalled freely without any cues.**

Memory index score (MIS):

Administration: Following the delayed free recall trial, the examiner provides a category (semantic) cue for each word the subject was unable to recall. Example: *"I will give you some hints to see if it helps you remember the words, the first word was a body part."* If the subject is unable to recall the word with the category cue, the examiner provides him/her with a multiple choice cue. Example: *"Which of the following words do you think it was, NOSE, FACE, or HAND?"* All non-recalled words are prompted in this manner. The examiner identifies the words the subject was able to recall with the help of a cue (category or multiple-choice) by placing a check mark (✓) in the appropriate space. The cues for each word are presented below:

Target Word	Category Cue	Multiple Choice
FACE	body part	nose, face, hand (shoulder, leg)
VELVET	type of fabric	denim, velvet, cotton (nylon, silk)
CHURCH	type of building	church, school, hospital (library, store)
DAISY	type of flower	rose, daisy, tulip (lily, daffodil)
RED	color	red, blue, green (yellow, purple)

* The words in parentheses are to be used if the subject mentions one or two of the multiple choice responses during the category cuing.

Scoring: To determine the MIS (which is a sub-score), the examiner attributes points according to the type of recall (see table below). The use of cues provides clinical information on the nature of the memory deficits. For memory deficits due to retrieval failures, performance can be improved with a cue. For memory deficits due to encoding failures, performance does not improve with a cue.

MIS scoring				Total
Number of words recalled spontaneously	...	multiplied by	3	...
Number of words recalled with a category cue	...	multiplied by	2	...
Number of words recalled with a multiple choice cue	...	multiplied by	1	...
Total MIS (add all points)				---/15

11. **Orientation:**

Administration: The examiner gives the following instructions: “*Tell me today’s date.*” If the subject does not give a complete answer, the examiner prompts accordingly by saying: “*Tell me the [year, month, exact date, and day of the week].*” Then the examiner says: “*Now, tell me the name of this place, and which city it is in.*”

Scoring: One point is allocated for each item correctly answered. The date and place (name of hospital, clinic, office) must be exact. No points are allocated if the subject makes an error of one day for the day and date.

TOTAL SCORE: Sum all subscores listed on the right-hand side. Add one point for subject who has 12 years or fewer of formal education, for a possible maximum of 30 points. A final total score of 26 and above is considered normal.

Please refer to the MoCA website at www.mocatest.org for more information on the MoCA.

MONTREAL COGNITIVE ASSESSMENT (MOCA®)

Version 8.1 English

Name:

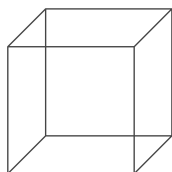
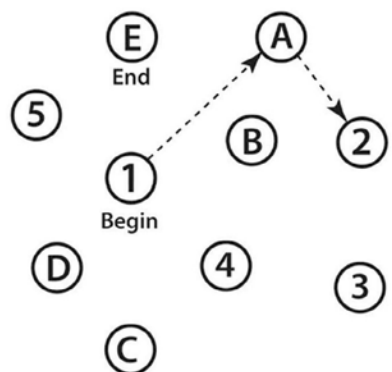
Education:

Sex:

Date of birth:

DATE:

VISUOSPATIAL / EXECUTIVE



Copy
cube

Draw CLOCK (Ten past eleven)
(3 points)

POINTS

[]

[]

[]

[]

[]

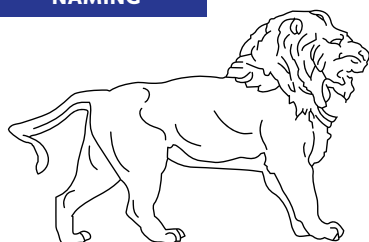
Contour

Numbers

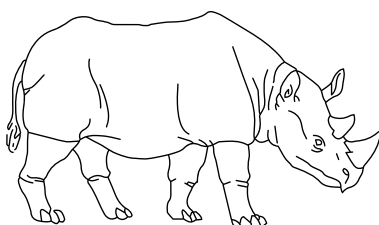
Hands

___/5

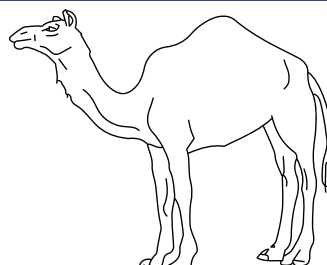
NAMING



[]



[]



[]

___/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED	
1 ST TRIAL						NO POINTS
2 ND TRIAL						

ATTENTION

Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order.

[] 2 1 8 5 4

Subject has to repeat them in the backward order.

[] 7 4 2

___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

___/1

Serial 7 subtraction starting at 100.

[] 93

[] 86

[] 79

[] 72

[] 65

4 or 5 correct subtractions: **3 pts**,

2 or 3 correct: **2 pts**,

1 correct: **1 pt**,

0 correct: **0**

___/3

LANGUAGE

Repeat: I only know that John is the one to help today. []

The cat always hid under the couch when dogs were in the room. []

___/2

Fluency: Name maximum number of words in one minute that begin with the letter F.

[] _____ (N \geq 11 words)

___/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit

[] train - bicycle

[] watch - ruler

___/2

DELAYED RECALL

(MIS)

Has to recall words
WITH NO CUE

FACE

[]

VELVET

[]

CHURCH

[]

DAISY

[]

RED

[]

Points for
UNCUED
recall only

___/5

Memory
Index Score
(MIS)

X3

Category cue

X2

Multiple choice cue

X1

MIS = ___/15

ORIENTATION

[] Date

[] Month

[] Year

[] Day

[] Place

[] City

___/6

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MIS: /15

(Normal \geq 26/30)

Administered by: _____

Training and Certification are required to ensure accuracy

Add 1 point if \leq 12 yr edu

TOTAL

___/30

MONTREAL COGNITIVE ASSESSMENT (MoCA®)

Version 8.2 English

Name:

Education:

Sex:

Date of birth:

DATE:

VISUOSPATIAL / EXECUTIVE

Copy chair

End

Begin

[] [] [] [] [] [] [] [] [] []

Draw CLOCK (Ten past nine)
(3 points)

POINTS

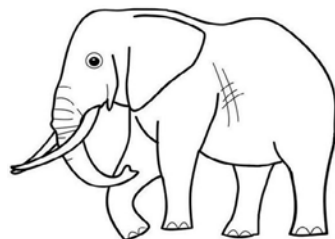
[] [] []
Contour Numbers Hands

___/5

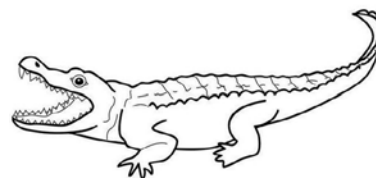
NAMING



[]



[]



[]

___/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	HAND	NYLON	PARK	CARROT	YELLOW
1st TRIAL					
2nd TRIAL					

NO POINTS

ATTENTION

Read list of digits (1 digit/sec.).

Subject has to repeat them in the forward order. [] 8 1 5 2 4
Subject has to repeat them in the backward order. [] 2 4 7

___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors.

[] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

___/1

Serial 7 subtraction starting at 70.

[] 63 [] 56 [] 49 [] 42 [] 35
4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt

___/3

LANGUAGE

Repeat: The robber of the gray car was stopped by the police. []
The student went back to school without his books and pencils. []

___/2

Language Fluency. Name maximum number of words in one minute that begin with the letter S. [] _____ (N ≥ 11 words)

___/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [] bed - table [] letter - telephone

___/2

DELAYED RECALL

(MIS)	Has to recall words WITH NO CUE	HAND	NYLON	PARK	CARROT	YELLOW	Points for UNCUE recall only
X3		[]	[]	[]	[]	[]	
X2	Category cue						
X1	Multiple choice cue						

MIS = ___/15

___/5

ORIENTATION

[] Date [] Month [] Year [] Day [] Place [] City

___/6

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www.mocatest.org

MIS: / 15

Administered by: _____

(Normal ≥ 26/30)

Training and Certification are required to ensure accuracy.

Add 1 point if ≤ 12 yr education

TOTAL

___/30

Montreal Cognitive Assessment [Evaluación Cognitiva Montreal] (MoCA)

Versión 8.1

Instrucciones para la administración y puntuación de los resultados

La Evaluación Cognitiva Montreal (Montreal cognitive assessment / MoCA) ha sido concebida para evaluar las disfunciones cognitivas leves. Este instrumento examina las siguientes habilidades: atención, concentración, funciones ejecutivas (incluyendo la capacidad de abstracción), memoria, lenguaje, capacidades visuoespaciales, cálculo y orientación. Cualquier persona que comprenda y siga sus instrucciones puede administrar el MoCA, si bien únicamente un profesional de la salud especialista en el ámbito cognitivo podrá interpretar sus resultados. El tiempo de administración requerido es de aproximadamente diez minutos. La puntuación máxima es de 30; una puntuación igual o superior a 26 se considera normal.

Todas las instrucciones pueden repetirse una vez.

1. Alternancia conceptual:

Administración. El examinador da las instrucciones siguientes: “*Me gustaría que dibujara una línea alternando entre cifras y letras, respetando el orden numérico y el orden alfabético. Comience aquí (señale el 1) y dibuje una línea desde el 1 hacia la letra A y, a continuación, de la A hacia el 2 y así sucesivamente. Termine aquí (señale la E)*”.

Puntuación. Se asigna un punto si el paciente realiza la siguiente secuencia: 1 – A – 2 – B – 3 – C – 4 – D – 5 – E, sin que ninguna línea se cruce. Si la persona no se autocorrigie inmediatamente después de cometer un error, es decir, no lo corrige antes de pasar a la parte del cubo, la puntuación debe ser 0. No se asignará ningún punto si la persona dibuja una línea conectando el final (E) con el principio (1).

2. Capacidades visuoespaciales (Cubo):

Administración. El examinador da las instrucciones siguientes, señalando el cubo: “*Me gustaría que copiara este dibujo de la manera más precisa posible*”.

Puntuación. Se asigna un punto si se realiza el dibujo correctamente.

- El dibujo debe ser tridimensional.
- Todas las líneas están presentes.
- Sin espacios o con poco espacio entre las líneas.
- No se añaden líneas.
- Las líneas son relativamente paralelas y aproximadamente de la misma longitud (los prismas rectangulares son aceptables)
- Debe mantenerse la orientación espacial del cubo.

No se asigna ningún punto si no se han cumplido todos los criterios anteriores.

3. Capacidades visuoespaciales (Reloj):

Administración. El examinador debe asegurarse de que la persona no mira el reloj mientras realiza la tarea y de que no hay ningún reloj a la vista. El examinador señala el espacio adecuado y da las instrucciones siguientes: “*Dibuje un reloj. Incluya todos los números y dibújelo señalando las 11 y 10 minutos*”.

Puntuación. Se asigna un punto por cada uno de los tres criterios siguientes:

- Contorno (1 pt.): Debe dibujar el contorno del reloj, ya sea un círculo o un cuadrado,

solo se aceptarán leves deformaciones, por ejemplo, alguna imperfección al cerrar el círculo. Si los números están dispuestos en círculo pero no se ha dibujado el contorno, este se considerará incorrecto.

- **Números (1 pt.):** Todos los números deben estar presentes, sin añadir ninguno; Los números deben seguir el orden correcto, estar bien colocados y situados aproximadamente en su cuadrante del reloj. Se aceptarán los números romanos. Los números deben estar dispuestos en círculo, aunque el contorno sea cuadrado. Todos los números deben estar situados dentro o fuera del contorno del reloj. Si la persona sitúa algunos números dentro del contorno del reloj y algunos fuera del contorno, no se le asignará ningún punto por Números.

- **Agujas (1 pt.):** Las dos agujas deben indicar la hora correcta. La aguja de las horas debe ser claramente más corta que la de los minutos. Las agujas deben estar centradas dentro de la esfera del reloj y su punto de unión debe estar cerca del centro del reloj.

4. **Identificación:**

Administración. El examinador señala cada dibujo, empezando por la izquierda, y dice: *"Dígame el nombre de este animal"*.

Puntuación. Se asigna un punto por cada una de las siguientes respuestas: (1) león (2) rinoceronte (3) camello o dromedario.

5. **Memoria:**

Administración. El examinador lee una lista de cinco palabras a un ritmo de una palabra por segundo, tras dar las siguientes instrucciones: *"Esta es una prueba de memoria. Le voy a leer una lista de palabras que debe recordar. Escuche con atención. Cuando acabe, dígame todas las palabras que pueda recordar. No importa el orden en el que me las diga"*. El examinador deberá marcar con una cruz, en el espacio reservado a dicho efecto, todas las palabras que el paciente repita en este primer intento. El examinador no debe corregir al paciente si este recuerda mal una palabra o dice una palabra que se parece a la correcta. Cuando el paciente diga que ya ha terminado (se haya acordado de todas las palabras) o cuando no pueda acordarse de más palabras, el examinador volverá a leer la lista de palabras tras dar las instrucciones siguientes: *"Ahora le voy a leer la misma lista de palabras una vez más. Intente acordarse del mayor número posible de palabras, incluyendo las que repitió en la primera ronda"*. El examinador marca con una cruz, en el espacio reservado a dicho efecto, todas las palabras que el paciente repita en el segundo intento. Al final del segundo intento, el examinador informará al paciente de que debe recordar estas palabras diciendo: *"Le volveré a preguntar estas palabras al final de la prueba"*.

Puntuación. En los intentos 1 y 2 no se darán puntos.

6. **Atención:**

Administración de Serie de números hacia delante. El examinador dará las siguientes instrucciones: *"Le voy a leer una serie de números y, cuando haya terminado, deberá repetirlos en el mismo orden en el que yo los he dicho"*. El examinador lee una secuencia de cinco números a un ritmo de uno por segundo.

Administración de Serie de números hacia atrás. El examinador dará las siguientes instrucciones: *"Le voy a leer otra serie de números y, cuando haya terminado, deberá repetirlos hacia atrás"*. El examinador leerá la secuencia de tres números a un ritmo de

uno por segundo. Si el paciente repite la secuencia hacia delante, el examinador no podrá pedirle en ese mismo momento que repita la secuencia hacia atrás.

Puntuación. Se asigna un punto por cada una de las secuencias repetidas correctamente (nota: el orden exacto de la secuencia numérica inversa es 2-4-7).

Vigilancia y administración. El examinador leerá una serie de letras a un ritmo de una por segundo, tras dar las instrucciones siguientes: “*Voy a leerle una serie de letras. Cada vez que diga la letra ‘A’, dé un golpecito con la mano. Cuando diga una letra que no sea la A, no dé ningún golpecito*”.

Puntuación. Se asigna un punto si no se comete ningún error o solo se comete uno (por ejemplo, la persona da el golpecito con una letra equivocada o no da el golpecito con la letra ‘A’).

Serie del 7, administración. El examinador dará las instrucciones siguientes: “*Ahora me gustaría que restara 7 de 100 y que continuara restando 7 a la cifra de su respuesta anterior hasta que le pida que pare*”. El paciente debe realizar un cálculo mental y, por lo tanto, no puede recurrir a contar con los dedos o con un lápiz y papel para realizar esta actividad. El examinador no podrá repetir las respuestas del paciente. Si el paciente pregunta cuál ha sido su última respuesta o qué número debe restar de su respuesta, el examinador responderá repitiendo las instrucciones si no lo ha hecho ya.

Puntuación. Esta prueba obtiene tres puntos en total. No dé ningún punto (0) por las restas incorrectas, dé 1 punto por una resta correcta, 2 puntos por dos o tres restas correctas y 3 puntos si el paciente hace cuatro o cinco restas correctas. Cada resta se evaluará separadamente, es decir, si el paciente responde con un número incorrecto pero resta 7 de dicho número, se contará como una resta correcta. Por ejemplo, el paciente puede contar “92 - 85 - 78 - 71 - 64”. “92” es incorrecto, pero todos los resultados de las restas siguientes son correctos. Esto cuenta como un error y la tarea debería puntuarse con un 3.

7. Repetición de frases:

Administración. El examinador dará las instrucciones siguientes: “*Ahora le voy a leer una frase. Repítala exactamente cuando yo termine* [pausa]: ***Solo sé que le toca a Juan ayudar hoy***”. Después de la respuesta, diga: “*Ahora voy a leerle otra frase. Repítala exactamente cuando yo termine* [pausa]: ***El gato siempre se esconde debajo del sofá cuando hay perros en la habitación***”.

Puntuación. Se asigna un punto por cada frase repetida correctamente. La repetición debe ser exacta. Se debe prestar atención a los errores de omisión (p.ej., olvidar “solo”), sustitución/adición (p.ej., sustituir “solo” por “siempre”), errores gramaticales/plurales incorrectos (p.ej. “se esconde” por “se escondía”), etc.

8. Fluidez verbal:

Administración. El examinador dará las instrucciones siguientes: “*Ahora, diga el mayor número posible de palabras que comiencen por la letra F. Le pediré que pare al minuto. No se permiten nombres, números y las formas conjugadas de un verbo. ¿Está preparado?* [Pausa] [Tiempo 60 seg.] ***Pare***”. Si el paciente nombra dos palabras seguidas que empiezan con otra letra del abecedario, deberá repetirle la letra correcta si aún no le ha repetido las instrucciones.

Puntuación. Se asigna un punto si el paciente dice 11 palabras o más en un minuto. El examinador anotará las respuestas del paciente en el margen o en el reverso de la hoja del test.

9. Abstracción:

Administración. El examinador pedirá al paciente que le explique qué tienen en común cada pareja de palabras, ilustrándolo con el ejemplo siguiente: “*Le diré dos palabras y me gustaría que usted me dijera a qué categoría pertenecen* [pausa]: *una naranja y un plátano*”. Si el paciente da la respuesta correcta, el examinador deberá decir: “*Sí, las dos pertenecen a esta categoría de frutas*”. Si el paciente responde de una manera concreta, el examinador deberá ofrecerle una pista adicional: “*Dígame otra categoría a la que también puedan pertenecer estas cosas*”. Si el paciente no da la respuesta correcta (*frutas*), el examinador deberá decir: “*Sí y las dos pertenecen también a la categoría de frutas*”. No dé otras instrucciones o explicaciones.

Tras el primer intento de prueba, el examinador deberá decir: “*Ahora, un tren y una bicicleta*”. Tras la respuesta, el examinador administrará el segundo intento diciendo: “*Ahora, una regla y un reloj*”. Podrá ofrecerse una pista (una sola para todo el apartado de abstracción) si no se ha dado ninguna en el primer ejemplo.

Puntuación. Solo se puntuarán los dos últimos pares. Se asigna un punto por cada par correcto. Se aceptan las siguientes respuestas:

- tren/bicicleta = medios de transporte, medios de locomoción, para viajar
- regla/reloj = instrumentos de medición, para medir

Las siguientes respuestas **no** son aceptables:

- tren/bicicleta = tienen ruedas
- regla/reloj = tienen números

10. Recuerdo diferido

Administración. El examinador dará las siguientes instrucciones: “*Antes le he leído una serie de palabras y le he pedido que las recordase. Dígame ahora todas las palabras de las que se acuerde*”. El examinador marca con una cruz las palabras que el paciente recuerde sin necesidad de pistas en el espacio reservado a dicho efecto.

Puntuación. Se asigna un punto por cada una de las palabras recordadas espontáneamente, sin pistas.

Puntuación de la escala de memoria (Memory Index Score, MIS):

Administración. Tras la prueba de recuerdo diferido, el examinador dará una pista de la categoría (semántica) correspondiente a cada palabra que el paciente no haya recordado. Ejemplo: “*Le daré algunas pistas para ver si le ayudan a recordar las palabras. La primera palabra era una parte del cuerpo*”. Si el paciente no puede recordar la palabra con ayuda de la pista sobre la categoría, el examinador deberá proporcionar una pista de elección múltiple. Ejemplo: “*¿Cuál de estas palabras cree usted que era NARIZ, ROSTRO o MANO?*” Se sugerirán de esta forma todas las palabras no recordadas. El examinador identificará las palabras que el paciente haya podido recordar con ayuda de una pista (de categoría o elección múltiple) marcando una cruz en el espacio apropiado. Las pistas para cada una de las palabras son las siguientes:

Palabra correcta	Pista de categoría	Elección múltiple
ROSTRO	parte del cuerpo	nariz, rostro, mano (hombro, pierna)
SEDA	tipo de tela	tela vaquera, seda, algodón (nylon, terciopelo)
TEMPLO	tipo de edificio	templo, escuela, hospital (biblioteca, tienda)
CLAVEL	tipo de flor	rosa, clavel, tulipán (azucena, margarita)
ROJO	color	rojo, azul, verde (amarillo, morado)

* Las palabras entre paréntesis se usarán si el paciente menciona una o dos de las respuestas de elección múltiple cuando se le dé la pista de la categoría.

Puntuación. Para determinar el MIS (que es una subpuntuación), el examinador asignará puntos según el tipo de recuerdo (véase tabla más abajo). El uso de las pistas proporciona información clínica sobre la naturaleza de los déficits de memoria. Cuando se trata de déficits de memoria a causa de un recuerdo fallido, el rendimiento puede mejorarse gracias a las pistas. Cuando se trata de déficits de memoria a causa de fallos de codificación, las pistas no mejoran el rendimiento.

Puntuación MIS				Total
Número de palabras recordadas espontáneamente	...	multiplicado por	3	...
Número de palabras recordadas con una pista de la categoría	...	multiplicado por	2	...
Número de palabras recordadas con pistas de elección múltiple	...	multiplicado por	1	...
Total MIS (sumar todos los puntos)				---/15

11. Orientación:

Administración. El examinador dará las siguientes instrucciones: “*Dígame en qué fecha estamos hoy*”. Si el paciente ofrece una respuesta incompleta, el examinador le apuntará de forma oportuna diciendo: “*Dígame [el año, el mes, la fecha exacta y el día de la semana]*”. A continuación, el examinador dirá: “*Ahora, dígame cómo se llama este lugar y en qué localidad nos encontramos*”.

Puntuación. Se asigna un punto por cada una de las respuestas correctas. La fecha y el lugar (nombre del hospital, clínica, consulta) deben ser exactos. No se asignará ningún punto si el paciente se equivoca por un día en el día del mes y de la semana.

PUNTUACIÓN TOTAL. Sume todos los puntos obtenidos en el margen derecho de la hoja. Añada un punto si el paciente tiene 12 años o menos de estudios, hasta un máximo de 30 puntos. Una puntuación igual o superior a 26 se considera normal.

Por favor, consulte la web del MoCA www.mocatest.org para más información sobre el MoCA.

MONTREAL COGNITIVE ASSESSMENT (MOCA®) (EVALUACIÓN COGNITIVA MONTREAL)

Versión 8.1 Spanis(Spain)

Nombre:
Nivel de estudios:
Sexo:

Fecha de nacimiento:
FECHA:

VISUOESPACIAL / EJECUTIVA		Copiar el cubo		Dibujar un RELOJ (Once y diez) (3 puntos)		PUNTOS		
				<div style="display: flex; justify-content: space-around;"> <div>[]</div> <div>[]</div> <div>[]</div> <div>[]</div> <div>[]</div> </div> <div style="display: flex; justify-content: space-around;"> <div>Contorno</div> <div>Números</div> <div>Agujas</div> </div>		___/5		
IDENTIFICACIÓN								
						___/3		
MEMORIA	Lea la lista de palabras, el paciente debe repetirlas. Haga dos intentos. Recuérdeselas 5 minutos más tarde.		ROSTRO	SEDA	TEMPLO	CLAVEL	ROJO	NINGÚN PUNTO
		1 ^{er} INTENTO						
		2 ^a INTENTO						
ATENCIÓN	Lea la serie de números (1 número/seg.) El paciente debe repetirlos en el mismo orden.	[] 2 1 8 5 4					___/2	
		El paciente debe repetirlos en orden inverso. [] 7 4 2						
Lea la serie de letras. El paciente debe dar un golpecito con la mano cada vez que se diga la letra A. No se asignan puntos si ≥ 2 errores.							___/1	
[] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B								
Restar de 7 en 7 empezando desde 100.		[] 93	[] 86	[] 79	[] 72	[] 65	___/3	
4 o 5 restas correctas: 3 puntos, 2 o 3 restas correctas: 2 puntos, 1 resta correcta: 1 punto, 0 restas correctas: 0 puntos								
LENGUAJE	Repetir: Solo sé que le toca a Juan ayudar hoy.	[]					___/2	
		El gato siempre se esconde debajo del sofá cuando hay perros en la habitación.						
Fluidez del lenguaje. Decir el mayor número posible de palabras que comiencen por la letra "F" en 1 minuto.							___/1	
[] _____ (N ≥ 11 palabras)								
ABSTRACCIÓN	Semejanza entre p. ej. plátano-naranja = fruta	[] tren-bicicleta	[] reloj-regla				___/2	
RECUERDO DIFERIDO	(MIS) Debe recordar las palabras SIN DARLE PISTAS	ROSTRO	SEDA	TEMPLO	CLAVEL	ROJO	Puntos por recuerdos SIN PISTAS únicamente	___/5
Puntuación de la escala de memoria (MIS)	X3	[]	[]	[]	[]	[]		
	X2	Pista de categoría						
	X1	Pista de elección múltiple					MIS = ___ / 15	
ORIENTACIÓN	[] Fecha	[] Mes	[] Año	[] Día de la semana	[] Lugar	[] Localidad	___/6	
© Z. Nasreddine MD		www.mocatest.org		MIS: /15				
Administrado por: _____				(Normal ≥ 26/30)				
Se requiere formación y certificado para garantizar la exactitud.		Añadir 1 punto si tiene ≤ 12 años de estudios		TOTAL		___/30		

VAMC SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu.

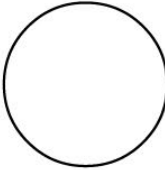
Name _____ Age _____




Is patient alert? _____ Level of education _____

____/1
____/1
____/1
____/3
____/3
____/5
____/2
____/4
____/2
____/8

1. What day of the week is it?
2. What is the year?
3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car
5. You have \$100 and you go to the store and buy a dozen apples for \$3 and a tricycle for \$20.
 - 1 How much did you spend?
 - 2 How much do you have left?
6. Please name as many animals as you can in one minute.
 1 0-4 animals 2 5-9 animals 3 10-14 animals 4 15+ animals
7. What were the five objects I asked you to remember? 1 point for each one correct.
8. I am going to give you a series of numbers and I would like you to give them to me backwards.
For example, if I say 42, you would say 24.
 1 87 2 649 3 8537
9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.

- 2 Hour markers okay
 - 2 Time correct


10. Please place an X in the triangle.

 - 1 Which of the above figures is largest?
11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.
 Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

- 2 What was the female's name?
 - 2 When did she go back to work?

- 2 What work did she do?
 - 2 What state did she live in?

TOTAL SCORE _____



SAINT LOUIS
UNIVERSITY



SCORING

HIGH SCHOOL EDUCATION		LESS THAN HIGH SCHOOL EDUCATION
27-30	Normal	25-30
21-26	MNCD*	20-24
1-20	Dementia	1-19

* Mild Neurocognitive Disorder

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. Am J Geriatr Psychiatry 14:900-910, 2006.



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Department of
Veterans Affairs

VAMC SLUMS Examination

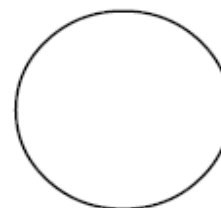
Name: _____ ID: _____ Age: _____
Educ: _____ Alert? _____ Date Given: _____

- _____/1 ① 1. Qué día de la semana es hoy? _____
- _____/1 ① 2. En qué año estamos? _____
- _____/1 ① 3. En qué estado estamos? _____
4. Por favor, recuerde los cinco objetos que le voy a nombrar. Mas tarde, le preguntaré nuevamente por ellos.
- Manzana Lapid Corbata Perro Casa
- _____/3 5. Usted tiene ciento dolares, y en la tienda compra una docena de manzanas por tres dolares y una bicicleta por veinte dolares.
- ① Cuánto dinero gastó? _____
- ② Cuánto dinero le queda? _____
- _____/3 6. Por favor en un minuto nombre todos los animales que pueda.
- ① 0-4 animals ① 5-9 animals ② 10-14 animals ③ 15+ animals
- _____/5 7. Cuáles fueron los 5 objetos que le dije que recordara?
- Manzana Lapid Corbata Perro Casa
- _____/2 8. Voy a decirle una serie de números. Me gustaría que usted me los dijera al revés. Por ejemplo, si yo digo 42, usted debe decir 24.
- ① 87 ① 649 ① 8537
- _____/4 9. Este círculo representa un reloj. Por favor escriba los números de las horas y las manecillas señalando las once menos diez.
- ② Hour markers correct?
- ② Time correct?
- _____/2 ① 10a. Por favor, señale el triángulo con una equis.
- ① 10b. Cuál de estas figuras es la mas grande?
- _____/8 11. Voy a contarle una historia. Por favor, escuche cuidadosamente, porque al terminar le voy a hacer unas preguntas sobre esta historia.
- María era una abogada muy exitosa y ganaba mucho dinero en la compañía donde trabajaba. Ella conoció a Carlos, un hombre muy apuesto, y, al cabo del tiempo, se casaron, tuvieron 3 hijos y vivían en Chicago. Ella dejo de trabajar para criar a sus hijos, y cuando estos fueron adolescentes ella volvió al trabajo. Ella y Carlos vivieron felices por siempre.
- ② Cuál era el nombre de la mujer? ② Cuando volvió a trabaja?
- ② Que profesión tenía ella? ② En que estado vivía?



_____/ Total Score

HS Educ		No HS Educ
27 - 30	Normal	25 - 30
21 - 26	MNCD	20 - 24
1 - 20	Dementia	1 - 19



The Quick Mild Cognitive Impairment (Qmci) Screen

Name: _____ DOB: _____ Gender: _____ Years in Education: _____ Date: _____ Time: _____

1: ORIENTATION

Ten seconds for each answer.

Give 2 points for correct answer,
1 if attempted but incorrect, 0 if no attempt.

What country is this? _____ / 2
What year is this? _____ / 2
What month is this? _____ / 2
What is today's date? _____ / 2
What day of the week is it? _____ / 2

SCORE

10

2: WORD REGISTRATION

"I am going to say 5 words. After I have said these 5 words, repeat them back to me."

30 seconds.

Give 1 point per word repeated, in any order, no hints. When finished, say....."Remember these words because I'll ask you to recall them later."

dog rain butter love door
Alternate word groups include...
cat dark pepper fear bed
rat heat bread round chair

5

3: CLOCK DRAWING

"Draw a clock face and set the time to 'ten past eleven'."
(circle provided over page)

One minute.

Give 1 mark for each number, 1 for each hand & 1 for the pivot correctly placed or close to their ideal location. Lose 1 mark for each number duplicated or, if greater than 12.

Numbers Correct + _____ / 12
Errors - _____
Hands + _____ / 2
Pivot + _____ / 1
Total + _____ / 15

15

4: DELAYED RECALL

"A few minutes ago I said five words. Please name as many words as you can remember."

30 seconds.

Recall in any order, within 30 seconds, giving 4 points per word, no hints.

dog rain butter love door
Alternate word groups include...
cat dark pepper fear bed
rat heat bread round chair

20

5: VERBAL FLUENCY

"Name as many animals as you can in one minute."

One minute.

Give half a point per animal named; to a maximum of 40. Accept all 'creatures' including birds, fish, insects etc.

Alternative forms include:
fruit & veg or towns & cities.

SCORE: 0.5 x number of animals =

List here, in 'shorthand' if required:

20

6: LOGICAL MEMORY

"I am going to read you a short story. When I am finished tell me as much of the story as you can."

One minute.

Give 2 points per highlighted word, recalled exactly, immediately within 30 seconds, in any order, no hints. Two alternatives are provided.

Story 1		Alternative version 1		Alternative version 2	
The red	It was a hot	The brown	It was a cold	The white	It was a warm
fox	May	dog	October	hen	September
ran across	morning.	Ran across	day.	Walked	afternoon.
the				across	
Ploughed	Fragrant	the metal	Ripe	the concrete	Dry
field.	Blossoms	bridge.	Apples	road.	Leaves
It was	were	It was	were	It was	were blowing
chased by	forming on	hunting	hanging on	followed by	in
a brown	the bushes.	a white	the trees.	a black	the wind.
dog.		rabbit.		cat.	

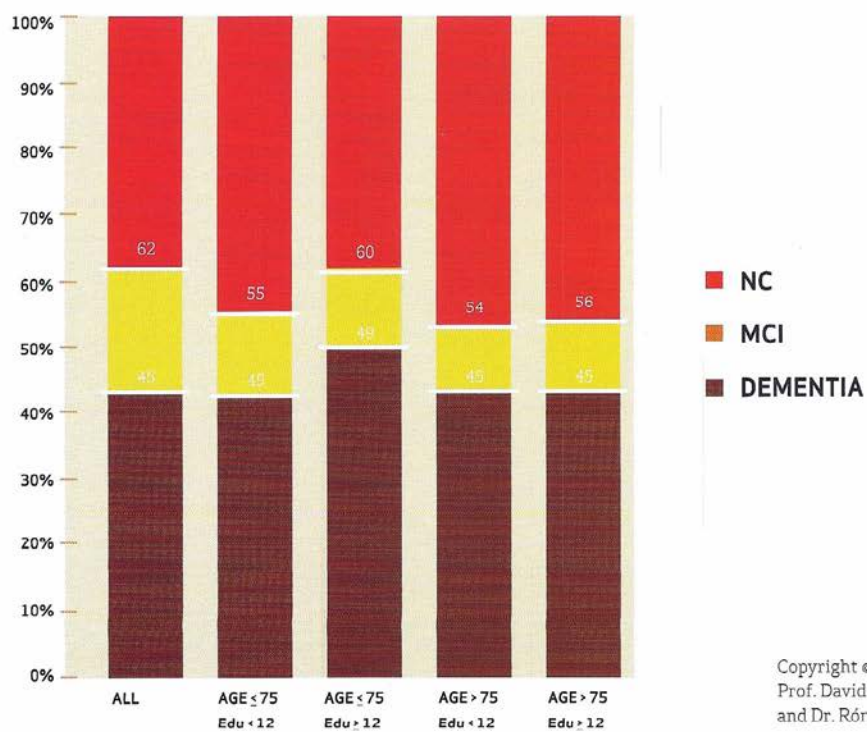
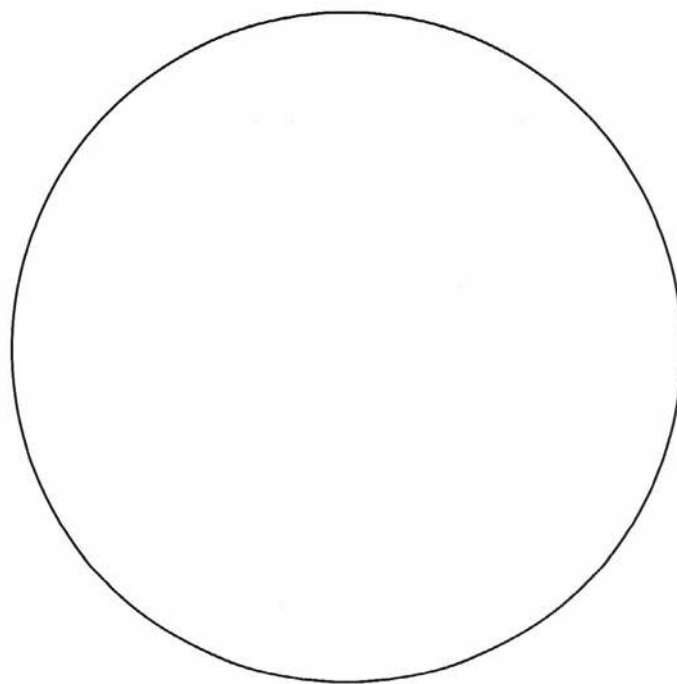
30

Administered by: _____

*Cognitive Impairment is suggested if the score <62/100 but requires adjustment for age and education.

Total score / 100*

100



The Quick Mild Cognitive Impairment (Qmci) Screen Administration and Scoring Guidelines

1. Orientation



Scoring

2 points for the correct answer, 1 point for wrong answers, and 0 points for no answer or a conceptually unrelated answer (see details below).



Timing

Maximum of 10 seconds for each answer.

Instructions and Scoring Guide

Year	If the person gives the correct year score 2 points, the incorrect year score 1 point, and 0 points if no year is given.
Country	Score 2 points for correct country, 1 point for incorrect country, and 0 if no country is named.
Month	Score 2 points for the correct month or for the previous or following month if within two days of the change of the month (for example, if the date is September 30 th , score the full 2 points if person answers October. Similarly, if the date is October 2 nd , score 2 points if person says September). Score 1 point if the month is incorrect and 0 if no month is named.
Date	Score 2 points for exact date or \pm one day, 1 point for any other date, 0 if no date is named.
Day of week	2 points for correct day, 1 point for incorrect day, 0 if no day named.

To begin say...

"I'd like to ask you some questions and give you some problems to solve. Would that be OK?"

What country is this? _____

What year is this? _____

What month is this? _____

What is today's date? _____

What day of the week is this? _____

Score _____ / 10

Qmci 2012
1

2. Word Registration

Instructions and Scoring Guide



Scoring

Score 1 point for each word recalled after the first reading. If subject recalls all five, repeat the five items once and then go on to clock drawing. If subject does not repeat all 5, repeat the 5 items and ask the subject to repeat them. Do this until the subject correctly recalls all 5 items or for a maximum of 3 trials. Do not score for trials 2 and 3. These trials are to help the person learn in preparation for the delayed recall task.



Timing

Say the words very deliberately, one per second. Allow 10 seconds for the recall.

To begin say...

"I am going to say 5 words. After I have said these 5 words, repeat them back to me. Are you ready?"

Dog	rain	butter	love	door
------------	-------------	---------------	-------------	-------------

Score _____ / 5

When finished, say... **"Remember these words because I'll ask you to recall them later."**

Alternate word groups include...

cat	dark	pepper	fear	bed
rat	heat	bread	round	chair

The Quick Mild Cognitive Impairment (Qmci) Screen Administration and Scoring Guidelines

3. Clock Drawing

Instructions and Scoring Guide



Scoring

Place the circle of the transparent scoring template over the circle of the patient's completed clock. Rotate the template circle so that the "12" s align. Score 1 point each if the 1, 2, 4, 5, 7, 8, 10, and 11 are in the correct quadrants. Score 1 point each if the 12, 3, 6, and 9 touch their quadrant lines. Subtract one point for each number repeated or for numbers above 12. (Should the patient not have drawn a "12" align the template with the 3, 6, or 9.)

Score the placement of hands according to the tips and pivot. Give 1 point for each hand between the dashed lines. Score 1 point for hands connecting at the pivot.



Timing

One minute.

To begin...

Give the sheet of paper with the pre-drawn circle and a pencil to the patient. Say **"Now put in the numbers like the face of a clock."** Then say **"Set the hands to show ten past eleven."** **Place the numbers and hands as carefully as you can."**

You may prompt at each stage..."put in the numbers.... put the time as ten past eleven".

Score:	Numbers	Correct	+ _____ / 12
		Errors	- _____
	Hands		+ _____ / 2
	Pivot		+ _____ / 1
	Total		+ _____ / 15

4. Delayed Recall

Instructions and Scoring Guide



Scoring

Score 4 points for each word recalled. Subjects may recall words in any order.



Timing

10 seconds.

To begin say...

A few minutes ago I named five words. Name as many of those words as you can remember.

dog rain butter love door

Score _____ / 20

Alternate word groups include...

cat	dark	pepper	fear	bed
rat	heat	bread	round	chair

5. Verbal Fluency

Instructions and Scoring Guide



Scoring.

Give ½ point for each correct word recalled to a maximum of 40 words. Round up the final score. Do not count words with different suffixes twice (e.g. fish / fishes, mouse / mice, etc.). Accept alternate species (e.g. blue jay, robin, sparrow, duck, etc.). Alternate forms include fruits and vegetables, cities and towns.



Timing.

60 seconds. Write down each word the patient says. (You may need to develop some kind of “shorthand” for the speedier patients, such as writing the first 3 letters of each word and then completing them later.)

To begin say...

“Name as many *animals* as you can in one minute. Ready? Go.”

Score _____ / 20

The Quick Mild Cognitive Impairment (Qmci) Screen Administration and Scoring Guidelines

6. Logical Memory

Instructions and Scoring Guide



Scoring.

Give 2 points for each correct word item recalled verbatim. All bolded words within each section must be recalled for score 2 points. Otherwise score 0. Recall may be in any order.



Timing.

30 seconds. Check off each word unit recalled.

To begin say...

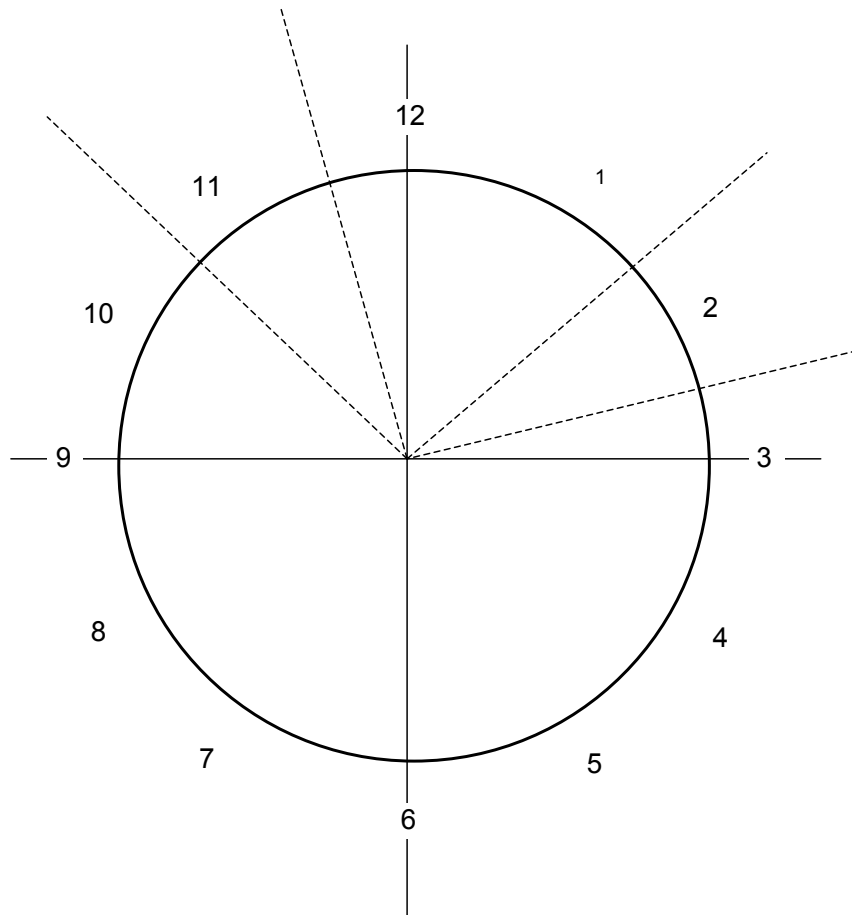
"I am going to read you a short story. After I have finished reading I want you to tell me as much of the story as you can. OK?" [patient signifies agreement, then begin reading the paragraph at about 1 second for each word unit] **"The red... fox... ran across..... the bushes."**

6. Logical Memory			
The red	The brown	The white	2 / 0
fox	dog	hen	2 / 0
ran across	ran across	walked across	2 / 0
the ploughed	the metal	the concrete	2 / 0
field.	bridge.	road.	2 / 0
It was chased by	It was hunting	It was followed by	2 / 0
a brown	a white	a black	2 / 0
dog.	rabbit.	cat.	2 / 0
It was a hot	It was a cold	It was a warm	2 / 0
May	October	September	2 / 0
morning.	day.	afternoon.	2 / 0
Fragrant	Ripe	Dry	2 / 0
blossoms	apples	leaves	2 / 0
were forming on	were hanging on	were blowing in	2 / 0
the bushes.	the trees.	the wind.	2 / 0

Score _____ / 30

Qmci Total Score _____ / 100

The Clock Transparency Scoring Template



Scoring

Place this scoring template over the completed clock with the template's "12 o'clock" line placed over the subject's 12. Adjust the template to maximize the score for the numbers and hands. The total score is 15. Record scores on the score sheet as follows:

Numbers

- For the numbers 12, 3, 6, and 9 score one (1) point if they touch their respective lines, zero (0) point if missed, and zero (0) if the number is omitted.
- For the numbers 1, 2, 4, 5, 7, 8, 10, and 11 score one (1) point for each number in the correct quadrant, zero (0) point if the number is outside the quadrant, and zero (0) if the number is omitted.
- **Subtract one point for each number repeated or more than 12.**

Hands

- Score the placement of the entire hand. If the hands are drawn within range, score one (1) point for each hand; if the hands are drawn outside the hatched line or are omitted score zero (0); Give one (1) point if the hands join at the pivot.

Patient Health Questionnaire (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or helpless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL: please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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A2662B 10-04-2005

Cuestionario De Salud Del Paciente (PHQ-9) + 3

Lista de los Nueve Síntomas para Revisión de la Depresión

Nombre del Paciente: _____ Fecha De Nacimiento: _____ Fecha: _____

¿En las últimas dos semanas, con qué frecuencia ha experimentado los siguientes síntomas?

PREGUNTAS	Nunca	Varios días	Más de la mitad de los días	Casi todos los días			
Conteste las preguntas 1-9 inicialmente y después todos los Puntos de Decisión Crítica (PDC)	0	1	2	3			
1. Poco interés o placer en hacer cosas	0	0	0	0			
2. Sentirse desanimado, deprimido o sin esperanza	0	0	0	0			
3. Tener problemas para dormir, mantenerse dormido o dormir demasiado	0	0	0	0			
4. Sentirse cansado o tener poca energía	0	0	0	0			
5. Poco apetito o comiendo demasiado	0	0	0	0			
6. Sentir falta de amor propio o pensar que es un fracaso o fallarle a usted mismo o a su familia	0	0	0	0			
7. Tener dificultad en concentrarse en cosas tales como leer el periódico o ver televisión	0	0	0	0			
8. El moverse o hablar tan despacio que otras personas a su alrededor se dan cuenta; o todo lo contrario, que cuando está nervioso/a o inquieto/a usted se mueva muchísimo más de lo normal.	0	0	0	0			
9. Pensamientos de que pudiera estar mejor muerto o hacerse daño a si mismo. (Si contestó afirmativamente, complete la Evaluación de Riesgo de Suicidio)	0	0	0	0			
PHQ-9 Scoring Formula							
# Symptoms	___ X 0 =	___ X 1 =	___ X 2 =	___ X 3 =			
Per Category	___ +	___ +	___ +	___ =			
PHQ-9 Total Score: _____							
10. Si contestó afirmativamente a cualquiera de los problemas en el cuestionario, ¿cuánta dificultad le han causado estos problemas en el trabajo, al atender su hogar o llevarse bien con otras personas?							
<input type="checkbox"/> Ninguna Dificultad	<input type="checkbox"/> Alguna Dificultad	<input type="checkbox"/> Mucha Dificultad	<input type="checkbox"/> Muchísima Dificultad				
COMPLETE LAS PREGUNTAS 11 Y 12 SOLAMENTE EN LA VISITA INICIAL							
11. ¿En los últimos dos años, se ha sentido deprimido/a o triste la mayoría de los días, a pesar de sentirse bien en otras ocasiones?							
<input type="checkbox"/> Si	<input type="checkbox"/> No						
12. ¿Ha habido un periodo, de al menos cuatro días, en los que se sentía tan feliz, con demasiada energía o tan irritable que se metió en problemas, o su familia o amigos se preocuparon o el médico le dijo que se encontraba en un estado maniaco?							
<input type="checkbox"/> Si	<input type="checkbox"/> No						
Número de Teléfono: _____ ¿Se puede dejar mensaje? SI or NO Nota: _____							
Medication: _____ Dose: _____ Frequency: _____							
1 st copy to Medical Record 2 nd copy to Initiate Phone Protocol							

Geriatric Depression Scale (short form)

Instructions:

Circle the answer that best describes how you felt over the past week.

- | | | |
|---|-----|----|
| 1. Are you basically satisfied with your life? | yes | no |
| 2. Have you dropped many of your activities and interests? | yes | no |
| 3. Do you feel that your life is empty? | yes | no |
| 4. Do you often get bored? | yes | no |
| 5. Are you in good spirits most of the time? | yes | no |
| 6. Are you afraid that something bad is going to happen to you? | yes | no |
| 7. Do you feel happy most of the time? | yes | no |
| 8. Do you often feel helpless? | yes | no |
| 9. Do you prefer to stay at home, rather than going out and doing things? | yes | no |
| 10. Do you feel that you have more problems with memory than most? | yes | no |
| 11. Do you think it is wonderful to be alive now? | yes | no |
| 12. Do you feel worthless the way you are now? | yes | no |
| 13. Do you feel full of energy? | yes | no |
| 14. Do you feel that your situation is hopeless? | yes | no |
| 15. Do you think that most people are better off than you are? | yes | no |

Total Score _____

Common scales used in the assessment of BPSD

(Adapted from Tampi et al. (2011)²¹)

SCALE	TIME FOR COMPLETION (MINUTES)	SCORE RANGE	HIGHER SCORE MEANS
GENERAL ASSESSMENT SCALES			
Behavioral Pathology in Alzheimer's Disease Rating Scale	20	0-75	Greater severity of behavioral symptoms
Columbia University Scale for Psychopathology in Alzheimer's Disease (CUSPAD)	25	0-51	Greater severity of behavioral symptoms
Consortium to Establish a Registry for Alzheimer's Disease Behavior Rating Scale for Dementia (CERAD-BRSD)	30	0-148	Greater severity of behavioral symptoms
Neuropsychiatric Inventory	20	1-144	Greater severity of behavioral symptoms
SPECIFIC ASSESSMENT SCALES			
Apathy Inventory (Clinician Version)	5	0-12	Greater apathy
Cohen-Mansfield Agitation Inventory (CMAI)	15	29-203	Greater severity of behavioral symptoms
Cornell Scale for Depression in Dementia	30	0-38	Greater severity of depression

Caregiver Assessment Zarit Burden ZBI-12



Short Form Zarit Burden Interview (ZBI-12)

	“Never” (0)	“Rarely” (1)	“Sometimes” (2)	“Quite frequently” (3)	“Nearly always” (4)
Do you feel...?					
That because of the time you spend with your relative that you don't have enough time for yourself?					
Stressed between caring for your relative and trying to meet other responsibilities (work/family)?					
Angry when you are around your relative?					
That your relative currently affects your relationship with family members or friends in a negative way?					
Strained when you are around your relative?					
That your health has suffered because of your involvement with your relative?					
That you don't have as much privacy as you would like because of your relative?					
That your social life has suffered because you are caring for your relative?					
That you have lost control of your life since your relative's illness?					
Uncertain about what to do about your relative?					
You should be doing more for your relative?					
You could do a better job in caring for your relative?					

- Short form ZBI-12 validated as screening tool in advanced illness including dementia and cancer
- Total ZBI-12 score: summation of 12 items (0 to 4 points per item, total score range 0 to 48)
- Copyrighted, but available for free use by clinicians and for non-funded academic research
- Suggested guidelines for scoring:
 - 0-10: no to mild burden
 - 10-20: mild to moderate burden
 - >20: high burden

Preparing for Your Doctor's Visit

Fill out the information below to the best of your ability. Share it with your doctor. Be open and honest in answering any questions your doctor may ask you about the changes you've been experiencing. It is recommended to bring someone with you, either a family member or someone who knows you well enough to contribute information and can take notes so you don't have to worry about remembering anything.

Has your health, memory or mood changed?

How did it change?

When did you first notice the change?

How often does it happen?

When does it happen? Is it always at a certain time of day?

What do you do when it happens?

What behaviors are the same?

Do you have problems with any of the following?

Please check the answer.

Repeating or asking the same thing over and over?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Remembering appointments, family occasions, holidays?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Writing checks, paying bills, balancing the checkbook?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Shopping independently (e.g., for clothing or groceries)?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Taking medications according to the instructions?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Getting lost while walking or driving in familiar places?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Medications and medical history

List of medications (dosage, frequency) including over-the-counter and prescription: (Bring all over-the-counter and prescription medications with you to your visit.)

List vitamins and herbal supplements:

List current medical conditions:

List past medical conditions:

What to bring with you to your doctor visit

Bring someone with you, either a family member or someone who knows you well enough to contribute information and can take notes so you don't have to worry about remembering everything.

Bring all over-the-counter and prescription medications.

Bring your Advance Directives if you have them.

Questions to ask the doctor

What are tests I need to take and how long will it take to get a diagnosis? Will you refer me to a specialist?

Could the medicines I'm taking be causing my symptoms?

Do I have any other conditions that could be causing my symptoms or making them worse?

What should I expect if it is Alzheimer's?

Which treatments are available for Alzheimer's? What are the risks and benefits and possible side effects?

What about participating in a clinical trial? What are the risks and benefits?

Is there anything else I should know?

When should I come back for another visit?

Where can I get information about Advance Directives if I don't have one yet?

This tool was amended from tools developed by the Alzheimer's Association. Some information in this tool was developed for the Chronic Care Networks for Alzheimer's Disease (CCN/AD) project and is the joint property of the Alzheimer's Association and the National Chronic Care Consortium.

Information, Organizations and Services

- 211: County-wide info/resources, <https://211sandiego.org>
- Aging & Independence Services: (800) 339-4661, specific info/resources for older adults, including Adult Protective Services, <https://www.sandiegocounty.gov/hhsa/programs/ais/>
- Alzheimer's Association: (800) 272-3900, Alzheimer's disease specific; <https://www.alz.org>
- Alzheimer's San Diego: (858) 492-4400, San Diego based resource organization; <https://www.alzsd.org>
- Caregiver Coalition of San Diego; (858) 505-6300, education and online resources, <https://caregivercoalitionsd.org>
- Jewish Family Service Older Adult Helpline (858) 637-3210, <https://www.jfssd.org>
- Southern Caregiver Resource Center: (800) 827-1008, Caregiver focused information and resources <https://www.caregivercenter.org>
- UC San Diego Shiley-Marcos Alzheimer's Disease Research Center: (858) 822-4800, <http://adrc.ucsd.edu>
- VA San Diego Healthcare System Caregiver Support. <https://www.caregiver.va.gov> (858) 642-1215

Respite and In-Home Services

- Southern Caregiver Resource Center: (800) 827-1008, <http://caregivercenter.org>
- Respite Voucher Program offers matching funding, funded by AIS: <https://www.countynewscenter.com/new-county-program-offers-relief-for-alzheimers-dementia-caregivers/>
- Respite Volunteer Program: Alzheimer's San Diego; (858) 492-4400, <https://www.alzsd.org>
- In-Home Care Resources: In-Home Supportive Services, (800) 339-4661, <http://sandiegocounty.gov/hhsa/programs/ais/>

Memory Care Living Communities

- ChooseWell: Listings and ratings of assisted living facilities; County HHSA; choosewellsandiego.org

Day Programs

- (PACE= Program of All-Inclusive Care for the Elderly)
- Family Health Centers of San Diego PACE; (619) 515-2445, <https://fhcsd.org/pace>
- Glenner Center: (619) 543-4700, <http://glenner.org>
- St. Paul's PACE Program; (619) 677-3800, <https://stpaulspace.org>
- San Ysidro Health Center PACE Program; (619) 662-4100, www.syhc.org/sdpac
- Gary & Mary West Senior Wellness Center; (619) 235-6572, <https://servingseniors.org>
- Gary & Mary West PACE (North County); (760) 280-2230, <https://westpace.org>

Financial, Insurance and Legal Resources

- California Department of Aging, (916) 322-5290, <https://www.aging.ca.gov>
- Health Insurance Resources: Health, Information, Counseling & Advocacy Program (HICAP), (858) 565-1392, <https://cahealthadvocates.org>
- Legal Resources: Elder Law & Advocacy, (858) 565-1392, <http://www.seniorlaw-sd.org>

Print Resources

- Caregiver Handbook, Caregiver Coalition of San Diego, <https://www.caregivercoalitionsd.org>
- Mace, N. & Rabins, P. The 36-Hour Day: A Family Guide to Caring for People with Alzheimer's Disease, other Dementias, and Memory Loss in Later Life.

Safety Resources

- Alzheimer's Association "Safe Return" program using identification products with toll free 800 numbers www.alz.org/SafeReturn
- Adult Protective Services: (800) 510-2020, for elder and disabled adult abuse reporting
- SD County Sheriff's "Take Me Home" Program and "You Are Not Alone" Program: <https://www.sdsheriff.gov/community/take-me-home-registry>

Transportation

- San Diego County Volunteer Driver Coalition; (888) 924-3228, <http://factsd.org>



The Challenge of Caring for an Individual Living with Dementia

STRATEGIES FOR CAREGIVERS

1. Promptly evaluate and treat behavioral symptoms. This is even more important than ever because doing so will help protect caregivers from burn out.
2. Build a caregiving team/expand the caregiving team
3. Learn and utilize optimal communication approaches when caring for a person with dementia.
4. Create an optimal environment that includes structure and activities.
5. Use community, online resources, and other technologies to their fullest:
 - Online resources and learning modules
 - Assisted living communities
 - COVID-19 adaptations have been made which allow safety to be maintained in spite of COVID-19 e.g. video visits

CREATE A CAREGIVING TEAM

- Share the caregiving burden with as many family members & friends as possible to help protect from stress related illnesses or burn out
- Make a list of family members (and friends and neighbors) who are willing and able to help and what special skills and talents they possess.
- Give family members specific tasks or assignments that, when possible, use their strengths and talents. Examples include: Preparing meals, running errands, walking the dog, mowing the lawn, doing laundry
- Assign out-of-town family members tasks that do not require them to be geographically close to the the patient:
 - Using email to keep all those interested informed
 - Set up a phone tree for efficient communication
- Caring for a family member with dementia can be extremely stressful. Habits of behavior and communication between family members may be intensified by the stress of the situation.
- Periodically solicit feedback and offer praise and thanks

RECOGNIZING AND RESPONDING TO BEHAVIOR CHANGES

- Behavior changes are a form of communication.
- When a person with dementia experiences a change in behavior the first goal is to determine the meaning or message being communicated.
- Sometimes the meaning or message will be simple or obvious but sometimes it may take a while to understand.
- Even though we are living through the COVID-19 pandemic, individuals living with dementia remain vulnerable to behavioral problems and the triggers for behavioral symptoms remain the same.
- Remember that the emotions and stress of a caregiver will likely be passed to the person who is living with dementia.

- Encourage all involved family members to become as educated as possible about their loved one's dementia, and their preferences and needs
- Encourage care giving family members to attend virtual support groups
- Do not hesitate to set limits if a particular family member is saying or doing things that hurt more than help
- Monitor each care giving family member for signs of physical or psychiatric illness or burn out
- Establish clear lines of authority and communication
- Utilize online courses on how best to communicate with and assist someone who has dementia (e.g. Teepa Snow teepasnow.com)



IMPROVING COMMUNICATION

- Make one request at a time
- Speak clearly and slowly
- Allow time for the patient to respond
- Maintain eye contact
- Assume a comfortable posture with arms and hands relaxed
- Identify the patient's affect and verbalize this for him/her
- Time communications optimally based on circumstances (e.g. hunger, fatigue, background noise, etc.)
- Remember that even when words may no longer convey meaning, volume, rate, and melody of speech may still convey information
- The need to be seen, heard and understood is a part of human nature and does not disappear simply because someone is living with dementia
- Putting a thought, need or emotion into words for them can sometimes be powerfully helpful
- Someone living with dementia may have preserved emotional intelligence
- Strive to avoid triggering feelings of shame

DISTRACTION TECHNIQUES

- Presentation of options: "This door is closed but this door is open."
- A compliment: "My that's a beautiful sweater!"
- A request for help: "Please help me fold these towels."
- Other possibly helpful distractions include: food, drink, music, humor.

HELPFUL ACTIVITIES TO IMPROVE COMMUNICATIONS

- | | |
|-------------------|--|
| • Arts and crafts | • Singing |
| • Baking | • Dancing |
| • Current events | • Telling jokes |
| • Exercise | • Reading |
| • Gardening | • Card games |
| • Grooming | • Table games |
| • Music | • Word games including crossword puzzles |
| • Pets | |
| • Reminiscing | |



WORKING WITH CAREGIVERS FOR HIRE TO CARE FOR AN INDIVIDUAL LIVING WITH DEMENTIA

Southern Caregiver Resource Center and Alzheimer's San Diego can assist you to assess the qualifications of caregivers-for-hire. To be COVID-safe, follow these:

- Contact the home health care provider and learn their protocols to reduce the spread of COVID-19.
- Check the home health care professional's temperature before they enter your home. Anyone with a temperature over 100.4° F should be excluded from providing care.
- Ask health care professionals if they have been exposed to anyone who has tested positive and if so, do not allow them into your home.
- Ensure that the health care professional washes their hands upon arrival and regularly throughout their time in your home.
- Ask the health care professionals to wear a mask.
- Be aware that bringing anyone into your home increases the risk of COVID.

HELPING THE PERSON LIVING WITH DEMENTIA FOLLOW CDC COVID-19 GUIDELINES

- Provide extra written reminders regarding important hygienic practices.
- Consider placing signs in the bathroom and elsewhere to remind people with dementia to wash their hands with soap for 20 seconds.
- Demonstrate thorough hand-washing.
- Alcohol-based hand sanitizer with at least 60% alcohol can be a quick alternative to hand-washing if the person with dementia cannot get to a sink or wash his/her hands easily.
- Request prescriptions for a greater number of days than usual to reduce trips to the pharmacy.
- Think ahead and make alternative plans for the person with dementia should adult day care, respite, etc. be modified or canceled in response to COVID-19.
- Think ahead and make alternative plans for care management if the primary caregiver should become sick.



El desafío de cuidar a una persona que vive con demencia

ESTRATEGIAS PARA CUIDADORES

1. Evalúe y trate rápidamente los síntomas del comportamiento. Esto es aún más importante que nunca porque hacerlo ayudará a proteger a los cuidadores del agotamiento.
2. Crear un equipo de cuidadores / ampliar el equipo de cuidadores
3. Aprenda y utilice enfoques de comunicación óptimos al cuidar a una persona con demencia.
4. Crear un entorno óptimo que incluya estructura y actividades.
5. Utilice la comunidad, los recursos en línea y otras tecnologías al máximo:
 - Recursos en línea y módulos de aprendizaje
 - Comunidades de vida asistida
 - Se han realizado adaptaciones de COVID-19 que permiten mantener la seguridad a pesar de COVID-19, p. visitas de video

DESARROLLE UN EQUIPO DE CUIDADO

- Comparta la carga del cuidado con tantos familiares miembros y amigos como sea posible para ayudar a protegerse de enfermedades relacionadas con el estrés o agotamiento.
- Haga una lista de miembros de la familia (y amigos y vecinos) que estén dispuestos y puedan ayudar y qué habilidades y talentos especiales poseen.
- Dé a los miembros de la familia tareas o asignaciones específicas que, cuando sea posible, utilicen sus fortalezas y talentos. Los ejemplos incluyen: preparar comidas, hacer mandados, caminar al perro, cortar el césped, lavar la ropa
- Asigne tareas a familiares de fuera de la ciudad que no exijan que estén geográficamente cerca del paciente:
 - Usar el correo electrónico para mantener informados a todos los interesados
 - Configurar un árbol telefónico para una comunicación eficiente
- Cuidar a un familiar con demencia puede ser extremadamente estresante. Los hábitos de comportamiento y comunicación entre los miembros de la familia pueden verse intensificados por el estrés de la situación.

RECONOCER Y RESPONDER A LOS CAMBIOS DE COMPORTAMIENTO

- Los cambios de comportamiento son una forma de comunicación.
- Cuando una persona con demencia experimenta un cambio de comportamiento, el primer objetivo es determinar el significado o el mensaje que se comunica.
- A veces, el significado o el mensaje será simple u obvio, pero a veces puede llevar un tiempo comprenderlo.
- A pesar de que estamos viviendo la pandemia de COVID-19, las personas que viven con demencia siguen siendo vulnerables a los problemas de conducta y los factores desencadenantes de los síntomas de conducta siguen siendo los mismos.
- Recuerde que las emociones y el estrés de un cuidador probablemente se transmitirán a la persona que vive con demencia.

- Solicite periódicamente comentarios, proporcione elogios y agradezca.
- Anime a todos los miembros de la familia involucrados a que se eduquen lo más posible acerca de la demencia y de las preferencias y necesidades del ser querido.
- Anime a los familiares que brindan cuidados a participar en grupos de apoyo virtuales
- No dude en establecer límites si algún familiar dice o hace cosas que duelen más que ayuden
- Monitorear a cada miembro de la familia que brinde cuidados para detectar señales de enfermedad física o psiquiátrica o agotamiento
- Establecer líneas claras de autoridad y comunicación.
- Utilice cursos en línea sobre la mejor manera de comunicarse y ayudar a alguien que tiene demencia (por ejemplo, Teepa Snow teepasnow.com)



MEJORANDO LA COMUNICACIÓN

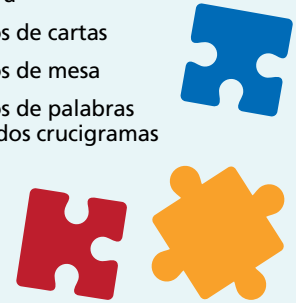
- Pida una cosa a la vez
- Hable clara y lentamente
- De tiempo para que el paciente responda
- Mantenga contacto visual
- Adopte una postura cómoda con brazos y manos relajados.
- Identifique el afecto en el paciente y verbalizarlo por el/ ella
- Programe las comunicaciones de manera óptima en función de las circunstancias (por ejemplo, hambre, fatiga, antecedentes, ruido, etc.)
- Recuerde que incluso cuando las palabras ya no transmitan significado, volumen, ritmo y melodía del habla aún puede transmitir información
- La necesidad de ser visto, escuchado y entendido es una parte de la naturaleza humana y no desaparece simplemente porque alguien vive con demencia
- Expresar un pensamiento, una necesidad o una emoción en palabras para ellos puede ser de gran ayuda
- Alguien que vive con demencia puede haber conservado la inteligencia emocional.
- Esfuércese por evitar provocar sentimientos de vergüenza

TÉCNICAS DE DISTRACCIÓN

- Presentación de opciones: "Esta puerta está cerrada pero esta puerta está abierta".
- Un cumplido: "¡Vaya, es un suéter hermoso!"
- Una solicitud de ayuda: "Por favor ayúdame a doblar estas toallas".
- Otras distracciones posiblemente útiles incluyen: comida, bebida, música, humor.

ACTIVIDADES ÚTILES PARA MEJORAR COMUNICACIÓN

- | | |
|------------------------|--|
| • Artes y manualidades | • Canto |
| • Hornear | • Bailar |
| • Eventos actuales | • Contar chistes |
| • Ejercicio | • Lectura |
| • Jardinería | • Juegos de cartas |
| • Aseo | • Juegos de mesa |
| • Música | • Juegos de palabras incluidos crucigramas |
| • Mascotas | |
| • Rememorando | |



TRABAJAR CON CUIDADORES CONTRATADOS PARA CUIDAR A UNA PERSONA QUE VIVE CON DEMENCIA

Southern Caregiver Resource Center y Alzheimer's San Diego pueden ayudarlo a evaluar las calificaciones de los cuidadores a sueldo. Para estar seguro durante COVID, siga estos pasos:

- Comuníquese con el proveedor de atención médica y conozca sus protocolos para reducir la propagación de COVID-19.
- Verifique la temperatura del profesional de la salud antes de que ingrese a su hogar. Cualquier persona que tenga una temperatura superior a 100,4 ° F debe excluirse de brindar atención.
- Pregunte a los profesionales de la salud si han estado expuestos a alguien que haya dado positivo en la prueba y, de ser así, no los deje entrar a su casa.
- Asegúrese de que el profesional de la salud se lave las manos a su llegada y con regularidad durante el tiempo que estén en su hogar.
- Pida a los profesionales de la salud que usen una mascarilla.
- Tenga en cuenta que traer a alguien a su hogar aumenta el riesgo de COVID

AYUDANDO A LA PERSONA QUE VIVE CON DEMENCIA SIGA LAS PAUTAS DE CDC COVID-19

- Proporcione recordatorios adicionales por escrito sobre prácticas higiénicas importantes.
- Considere colocar letreros en el baño y en otros lugares para recordar a las personas con demencia que deben lavarse sus manos con jabón durante 20 segundos.
- Demuestre lavarse las manos minuciosamente.
- Desinfectante de manos a base de alcohol con al menos un 60% de alcohol puede ser una alternativa rápida al lavado de manos si la persona con demencia no puede lavarse las manos fácilmente.
- Solicite recetas por una mayor cantidad de días de lo habitual para reducir los viajes a la farmacia.
- Piense en el futuro y haga planes alternativos para persona con demencia para el cuidado para adultos y cuidados de respiro por si los programas son modificados o cancelados en respuesta a COVID-19.
- Piense en el futuro y haga planes alternativos para el cuidado por si el cuidador principal llega a enfermarse.

Effective Communication with Individual with Cognitive Issues

Tips for improved communications:

- Make just one request at a time.
- Speak slowly with good diction.
- Allow time for the individual to respond to your question or request.
- Use many of the five senses with the individual: sight, smell, touch, taste, sound.
- Maintain eye contact.
- Assume a comfortable, relaxed posture to make the individual at ease.
- Identify and reflect the individual's concerns, "I see you are uncomfortable..."
- Use simple, direct statements or requests.

Using Redirection to Improve Communications

Redirection is an intention method of refocusing the individual to remain calm, cooperative, content and safe. Often, individuals with cognitive issues may be frustrated or agitated due to their inability to effectively communicate or have their needs met. It is key to enter the individual's reality, approach in a calm manner, and communicate your desire to help.

- Present options: "Would you like this or this?"
- Compliment: "My that's a beautiful sweater!"
- Request Help: "Can you please help me fold these towels?"
- Helpful Distractions: Food, drink, reminiscent

stories, music, humor

- Validate: "You look worried."
- Distract: "Let's look over there..." "Let's plan to do that later. In the meantime, ..."
- Redirect: "That coffee smells good. Do you want a cup?"

Common Delusions in Individuals with Dementia

- Accusations of infidelity,
- Persons or images from TV are real,
- Fear of abandonment,
- Accusations of theft of one's property,
- Claims of impersonation (spouse is imposter),
- Current residence is not one's home,
- Misidentification of familiar persons.





ALZHEIMER'SProject

San Diego unites for a cure and care



LIVE WELL
SAN DIEGO
LIVEWELLSD.ORG

<https://championsforhealth.org/alzheimers>