WELCOME!

Before we get started:

- Please scan the QR code or visit the following link to register-
  - https://forms.gle/AWiMBWmMWajdEkwJA
  - The QR code/link should bring you to the following page (PLEASE FILL OUT ALL MANDATORY QUESTIONS):

DEMENTIA
Care Aware

Early detection. Better care.

Learning Objectives

1. UNDERSTAND THE WHY'S AND WHAT'S OF DEMENTIA SCREENING AND CARE

2. LEARN HOW TO CONDUCT A SCREENING CALLED THE COGNITIVE HEALTH ASSESSMENT: TOOLS, SCORING, AND INTERPRETING

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

1. **THERE'S A POSITIVE SCREEN, WHAT ARE THE NEXT STEPS?**
2. **BILLING REQUIREMENTS**

The Impact of Dementia is Increasing in CA

BY THE NUMBERS = Prevalence, Lifetime Risks, Cause of Death

- Between 2019 and 2040, the **population of California will expand by 16%,** whereas the population of people living with Alzheimer's disease (AD) **will expand by 127%.**

- Among California's residents who live to be 65, **one in five people will develop dementia**.

- Between 2014 and 2017, AD accounted for **28% as the cause of death** (the greatest increase in causes of death in CA)

(Ross, L, Beld, M, and Yeh, J. (2021). Alzheimer's Disease and Related Dementias Facts and Figures in California: Current Status and Future Projections. Report prepared for the California Department of Public Health, Sacramento, CA at the Institute for Health and Aging, University of California, San Francisco, CA.)

The Types of Cognitive Decline: More Than Just Memory

"Cognitive decline **is not** just memory decline."

The Types of Cognitive Decline: Six Domains of Cognition

1. The Learning and Memory Domain
1. Executive Function
2. Complex Attention
3. Visuospatial Function
4. Social Cognition
5. Language

Types of Cognitive Decline

Type of Cognitive Decline	Magnitude of decline	Affects Daily Function?
Age-related decline	**Normal** decline in cognitive functions for age	No
Mild Cognitive Impairment (MCI)	**Abnormal** decline in cognitive functions for age	No. May be using compensatory strategies to accomplish activities of daily living.
Dementia	**Abnormal** decline in cognitive functions for age	Yes. Unable to use compensatory strategies to accomplish activities of daily living.

DEMENTIA Care Aware

Suggests Age-Related Cognitive Decline	Suggests Abnormal Cognitive Decline
The patient cannot remember details of a conversation or event that took place a year ago.	The patient cannot recall details of recent events or conversations.
The patient cannot remember the name of an acquaintance they don't see frequently.	The patient cannot remember the names of close family members.
The patient forgets things and events occasionally.	The patient forgets things or events nearly on a daily basis.
The patient occasionally has difficulty finding words.	The patient frequently pauses and substitutes when finding words.
The patient is worried about their memory, but their relatives are not.	The patient's relatives are worried about their memory, but the patient is not aware of any problems.

REMEMBER:

Age-Related Cognitive Decline Is NOT a Disease

What Cognitive Functions Decline in Normal Aging?

COGNITIVE FUNCTIONS THAT ARE VULNERABLE TO THE DECLINE IN AGING ARE:

- Short-term memory
- More time and effort to recall new information
- Decreased efficiency (e.g., divided attention and multitasking)
- Slower learning speed

Did You Know?

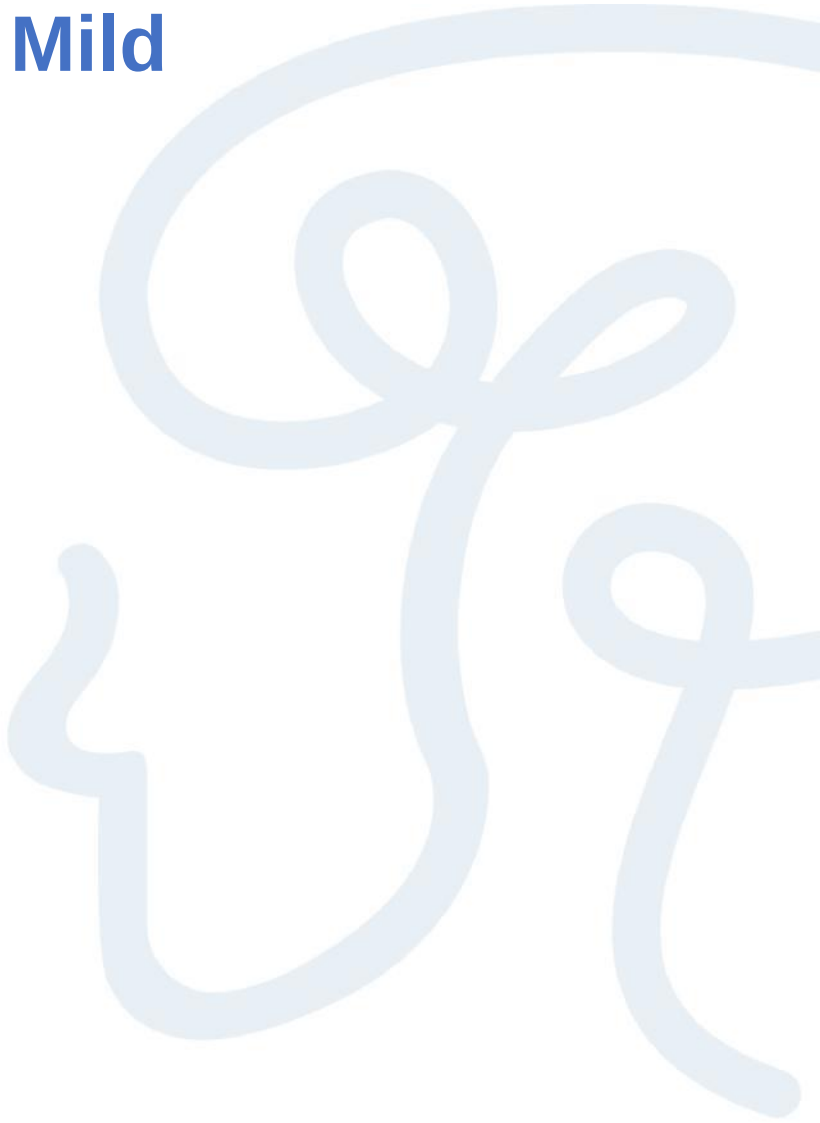
It's often someone who knows the patient well who first notices signs or symptoms of cognitive decline and brings them to the attention of a medical provider. However, many also attribute these signs to "old age" and may not think of bringing them up to a provider.

What Is Mild Cognitive Impairment (MCI) or Mild Neurocognitive Disorder (MINCD)?

A. When a person shows subjective signs or symptoms of cognitive decline in one or more cognitive domains

A. These changes are substantiated by cognitive testing.

B. The person has an intact ability to live independently and shows no impairment in social and/or occupational functioning.



What Is Dementia?

Dementia is also known as Major Neurocognitive Disorder (MaNCD).

Persons must exhibit the following three criteria:

1. Acquired Cognitive Decline
2. Acquired Functional Decline
3. No Other Causes

Acquired Cognitive Decline

1. The person must have an acquired cognitive decline from their prior level of ability in at least one cognitive domain.

Remember the SIX Domains?

learning and memory, language, executive function, complex attention, visuospatial skills, and social cognition.

Acquired Decline in Function

2. The person must have an acquired decline in function from their prior level of ability:

- One or more Instrumental Activities of Daily Living (IADLs) or Activities of Daily Living (ADLs).

No Other Causes

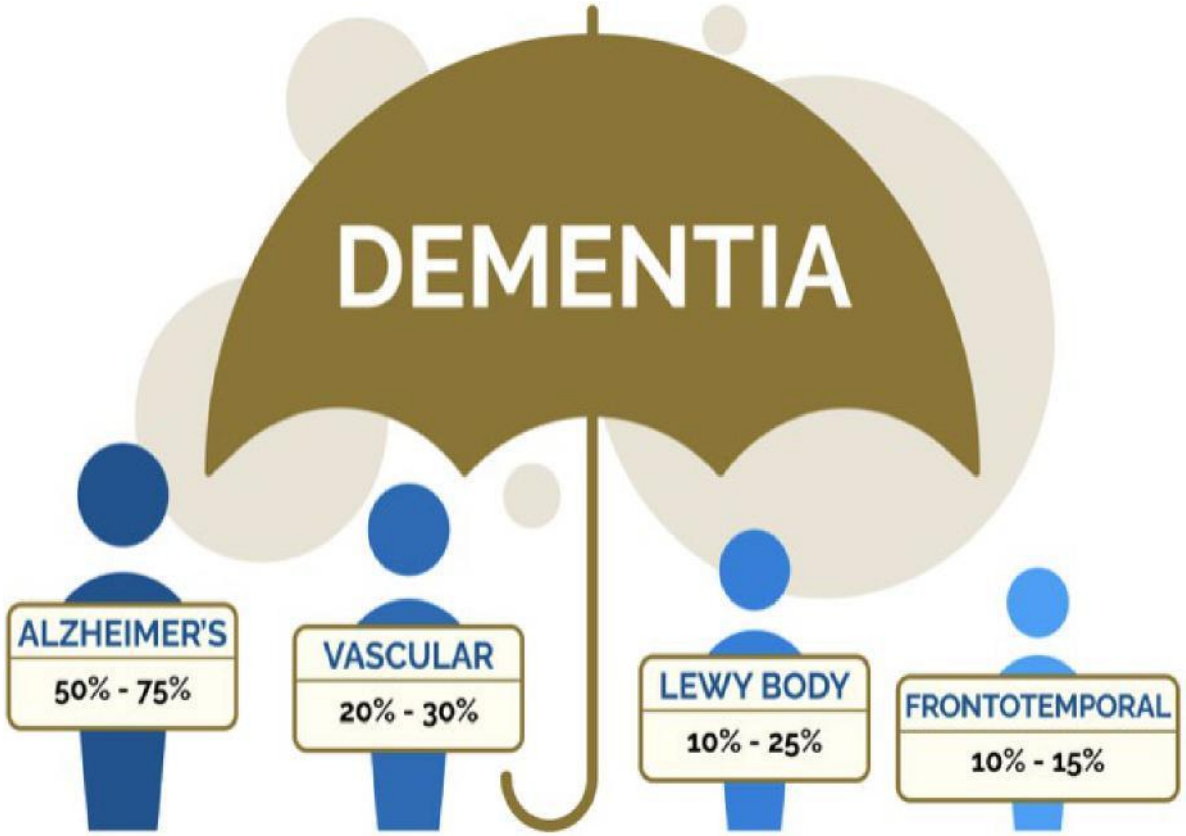
The patient must not have any other medical or psychiatric disorders that may explain their cognitive decline.

DEMENTIA: AN UMBRELLA TERM

Dementia is an "umbrella" term that describes the syndrome of cognitive and functional decline.

Alzheimer's disease, the most common, makes up **50%-75%** of all cases.

Vascular dementia is thought to cause **20%-30%** of cases and often coexists with AD, also called **"mixed dementia."**



Let’s REVIEW and try some case studies.

DEMENTIA Care Aware

MEET MR. AHOKA: Please read case

Mr. Ahoka is a **71-year-old man** who has poorly controlled hypertension, had a stroke 20 years ago, and uses tobacco.

Several family members have dementia.

He reports he has trouble **“recalling conversations” and misplaces things**. He lost his phone twice. He gets very angry when he can’t find things, and this was not his personality before.

Let’s Review Mr. Ahoka’s Screening Results

- Mr. Ahoka's score on a validated brief **cognitive screen** suggested cognitive impairment.
- His PCP then reviewed his **functional abilities** by asking about basic and instrumental activities of daily living. Mr. Ahoka reported that he cannot independently do instrumental activities of daily living. For example, his sister now pays his bills, does his shopping, and prepares his meals.

At a follow-up after this positive cognitive health assessment screening result:

- His PCP ordered lab work searching for reversible causes of cognitive impairment and reviewed his medications for possible cognitive side effects, and found **no clear causes** for his symptoms.
- Mr. Ahoka also had a **negative screen for depression and substance use.**

Which type of cognitive impairment do you think Mr. Ahoka is showing?

1. Age-Related Decline

2. Mild Cognitive Impairment (MCI)

3. Dementia

MEET MS. HADBURY

- Ms. Hadbury is a **73-year-old woman** whose mother had late-life dementia.
- She reports a concern for cognitive decline to her PCP. The patient has insight into her cognitive symptoms and provides several examples to illustrate what she experiences.
- **She cannot pick up new skills or information as well, such as a recent class she took in which she could not remember the information** from one class to the next.
- She also noticed that drawing, a hobby she loves, has become more difficult.

Let’s Review Ms. Hadbury’s Screening Results

- Ms. Hadbury's score on a validated brief cognitive screen **suggests cognitive impairment.**
- Her PCP then reviewed her functional abilities by asking about basic and instrumental activities of daily living. Ms. Hadbury says in the last two years she has had to take a list with her to the grocery store or she’ll forget what she came for, but otherwise **she is doing all activities independently.**

.

After this positive cognitive health assessment screening result:

- Her PCP ordered lab work searching for reversible causes of cognitive impairment, and all **results are normal**. She's not on any medications that have cognitive side effects.
- Ms. Hadbury also had a **negative screen for depression and substance use**

Which type of cognitive impairment do you think Ms. Hadbury is showing?

1. Age-Related Decline

2. Mild Cognitive Impairment (MCI)

3. Dementia

CONGRATULATIONS! Now you know the three types of cognitive decline. Let’s discuss the benefits of early dementia detection.

Benefits of Early Cognitive Assessments

- Improves quality of life for affected persons and caregivers.
- Reduces unnecessary costs of care.
- Increases the likelihood of benefiting from evidence-based dementia prevention strategies.
- Can address racial disparities in cognitive impairment among Black, Indigenous, Latino and other communities which are currently underserved.

Introducing the "Cognitive Health Assessment"

DEMENTIA Care Aware

The CHA is Designed Specifically for Primary Care Providers and Busy Clinics

It includes assessments that are

- Free to use
- Quick to administer
- Easy to score
- Validated in primary care
- Available in multiple languages

A Starting Place

Learning the CHA will enable you to start the process of detecting cognitive decline in your patient.

DEMENTIA Care Aware

HOW TO CONDUCT THE CHA

"Cognitive Health Assessment"

DEMENTIA Care Aware

Three Key Steps

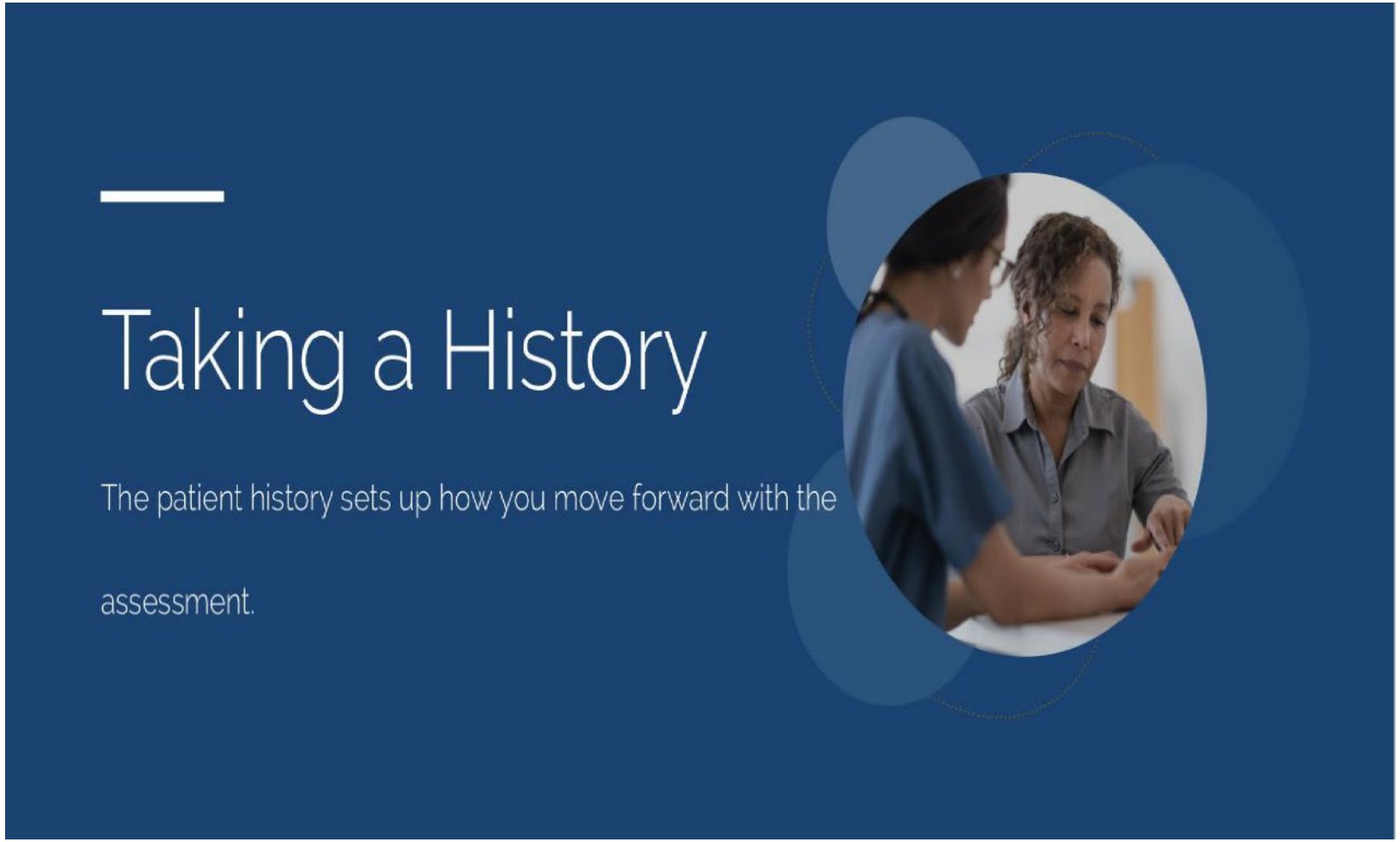
1. Take a brief patient history.
2. Use screening tools.
3. Document care partner information.

DEMENTIA Care Aware

1 Start by Taking a Brief Patient History

History or signs of decline can come from many sources—from the patient, an informant, or you or your team members.

Remember to document the source of the information .



Obtaining and documenting a **brief patient history** is the foundation to start a **brain health plan**.

Tip: Establish a Partnership

If possible, involve a patient's support person as soon as possible, starting with history-taking. It sets the stage for an ongoing partnership in care—between you, the patient, and their support person. This also helps in the next step of the assessment.

Step 2: Use Screening Tools

The next CHA step is to assess

- the patient's **cognition**
- the patient's **function** and
- obtain collateral information from an **informant**.

The table below provides examples of validated tools for assessing a patient's cognition and function with the patient and an informant.

	Cognitive Screen Tools	Functional Screen Tools
Patient	GP-COG OR Mini-Cog	ADL/IADL
Informant	AD-8 OR Short IQ-CODE	GP-COG Informant Interview OR FAQ

GP-COG: General Practitioner assessment of Cognition
Mini-Cog: This is a short cognitive assessment; Mini-Cog is not a shortened name.
ADL: Activities of Daily Living
IADL: Instrumental Activities of Daily Living
AD-8: Eight-item Informant Interview to Differentiate Aging and Dementia **Short IQ-CODE**: Short Informant Questionnaire on Cognitive Decline in the Elderly
FAQ: Functional Activities Questionnaire

GP-COG: Overview and Scoring

Quick facts:

- Time to administer: 4-5 min
- Domains tested: visuospatial, executive, orientation, memory
- Accessibility: Available in multiple languages
- Web-based with automatic scoring
- Noteworthy: The address used in the test could be strange to people
- Not adjusted for a patient's education level

Scoring: There are a total of 9 points. The first question regarding name and address is worth up to 5 points. The other items are worth one point each. 0-4 indicates cognitive impairment. 5-8 indicates more information is needed.

9 (out of 9) indicates no significant cognitive impairment.

GP-COG Informant Interview

Quick facts:

- Time to administer: 2 min
- **Six questions**
- **Web-based with automatic scoring**
- Accessibility: Available in multiple languages

Scoring: "Yes" responses indicate impairment. Any question not answered with a "yes" counts as 1 point. There are a total of 6 points.

0-3 indicates cognitive impairment.

4-5 indicates less impairment.

Patient name: _____ **Date:** _____

GPCOG Screening Test

Step 1: Patient Examination

Unless specified, each question should only be asked once

Name and Address for subsequent recall test

1. *"1 am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington."* (Allow a maximum of 4 attempts).

	Correct	Incorrect
Time Orientation		
2. *What is the date?* (exact only)	☐	☐
Clock Drawing - use blank page		
3. *Please mark in all the numbers to indicate the hours of a clock* (correct spacing required)	☐	☐
1. *Please mark in hands to show 10 minutes past eleven o'clock* (11.10)	☐	☐
Information		
1. *Can you tell me something that happened in the news recently?* (Recently = in the last week. **If a** general answer is given, eg "war", "lot of rain", ask for details. Only specific answer scores).	☐	☐
Recall		
1. *What was the name and address I asked you to remember*		
John	☐	☐
Brown	☐	☐
42	☐	☐
West (St)	☐	☐
Kensington	☐	☐

(To *get a total score, add the number of items answered correctly*
Total correct (score out of 9) *19*

If patient scores 9, no significant cognitive impairment and further testing not necessary.

If patient scores 5-8, more information required. Proceed with Step 2, informant section.

If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

Informant interview

Date: _____

Informant's name: _____

Informant's relationship to patient, i.e. informant is the patient's:

These six questions ask how the patient is compared to when s/he was well, say 5 — 10 years ago

Compared to a few years ago:

	Yes	No	Don't Know	N/A
• Does the patient have more trouble remembering things that have happened recently than s/he used to?	☐	☐	☐	
• Does he or she have more trouble recalling conversations a few days later?	☐	☐	☐	
▪ When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?	☐	☐	☐	
• Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?	☐	☐	☐	☐
• Is the patient less able to manage his or her medication independently?	☐	☐	☐	☐
• Does the patient need more assistance with transport (either private or public)? **(If the** patient has difficulties due only to physical problems, e.g bad leg, tick 'no')	☐	☐	☐	

(To get a total score, add the number of items answered 'no', 'don't know' or 'N/A'

Total score (out of 6)

If patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.

Mini-COG (Patient)

Quick facts:

- Time to administer: 2-3 min, no more than 5 min
- Domains tested: visuospatial, executive, memory
- Accessibility: Available in multiple languages
- Not adjusted for a patient's education level

Mini-Cog makeup:

1. Recall test of three words
2. Clock drawing test

Scoring: There are a total of 5 points. Less than 3 points is abnormal.

0-2 indicates a high likelihood of dementia.

3-5 indicates a low likelihood of dementia.

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.'' 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 h."

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.

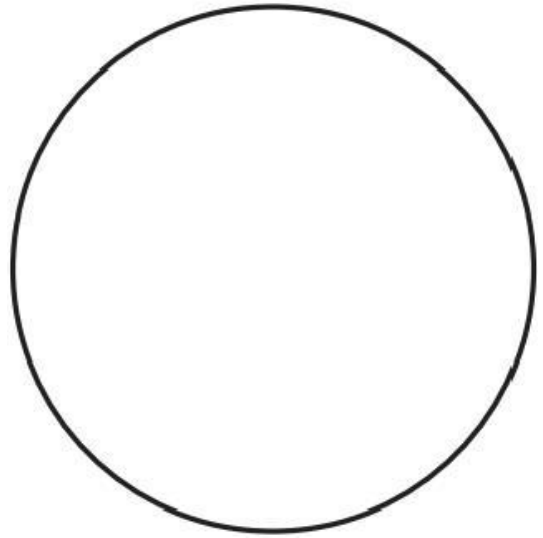
Word List Version: Person's Answers: _____ _____ _____

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 [hell and 2 (RIO). Hand length is not scored. Inability or refusal to draw a clock (abnormal) - 0 points.
Total Score: _ (0-5 points)but	Total score - Word Recall score • Clock Draw score. A cut point of <3 on the Mini-Cog"' has been validated *for* dementia screening. 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: _____



References

1.8orson S. Scanlan JM. Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population-based sample. J Am Geriatr Soc 2003:51:1451-1454.

Borson S. Scanlan JM. Watanabe Jet al. Improving identification of cognitive impairment in primary tare. Int J Geriatr Psychiatry 2006:21: 349-355.

3. Lessig M. Scanlan J et al.Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June: 20(3): 459-470.

1. Tsoi K. Chan Jet a I. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015: 61-69.

2. McCarten J. Anderson Petal. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 20n:59: 30g-213.

3. McCarten J. Anderson Petal. Finding dementia In primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012:60:210-217.

4. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2005:16:216-222.

Table of Commonly Asked ADLsZIADLs

Activities of Daily Living		
Activities of Daily Living	Bathing Dressing Transferring from bed to chair	ToiLeting Grooming Feeding oneself
Instrumental Activities of Daily Living	Using the telephono Preparing meals Managing housenoLd finances Taking medications	Doing Laundry Doing housework Shopping Managing transportation

3. Establish and document a patient's support person and/or a health care agent.

Many people may be involved in a person's care to different degrees and for different purposes. There are three roles to define that are involved in the CHA process:

- **an informant-** can give you information
- **a support person-** someone who helps with care
- **a health care agent-** someone who has legal authority if that person is unable to make their own decisions

"Do you have anyone who is available to speak with me and who knows you well?"

If someone has cognitive decline, it often becomes crucial to understand their support system and navigating the designation of a health care agent.

Case Study: Mrs. Pérez and Ana

TAKE A BRIEF HISTORY:

Mrs. Pérez—72 years old—reports progressive difficulty remembering what she has to do in a day.

She forgot to pick up her grandson at school and sometimes gets “lost in time” and forgets what she’s doing in the middle of a task.

She brings her daughter Ana to the visit today.

You decide to use the GP-COG for both Mrs. Perez and Ana, since it’s web-based and automatically scores.

Screening Test: GPCOG

RESULTS OF THE GPCOG TEST

GPCOG

Testing date: 3 June 2022

Patient name: Mrs. Perez

Date of birth: 1 March 1950

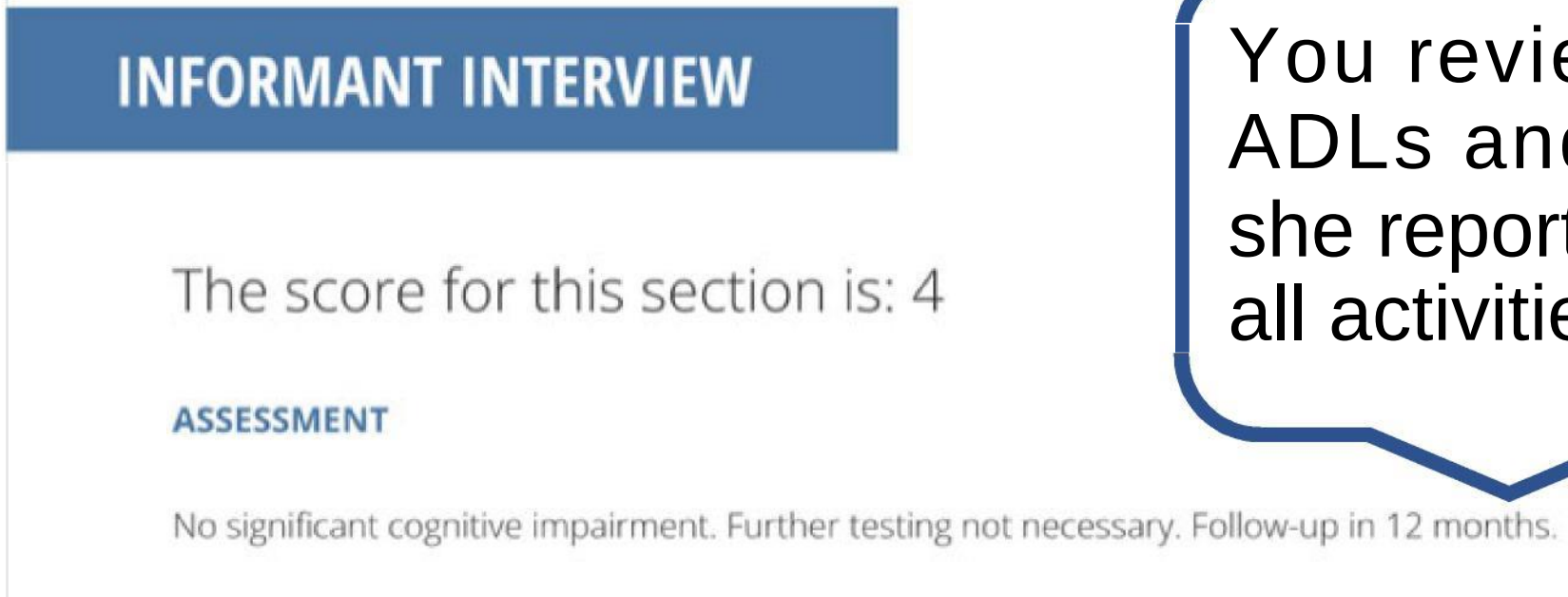
The score for this section is: 4 +

ASSESSMENT +

More information is required. Proceed with informant interview (/index/informant-interview).

With her challenges in recall skills and the clock, Mrs. Perez score of 4 indicates cognitive impairment

GP-COG Function: Informant Interview with Ana



You review Mrs. Perez's ADLs and IADLs, and she reports she can perform all activities independently.

What is the result of the cognitive and functional tests for Mrs. Pérez?

1. Negative for cognitive decline, negative for functional decline
2. Negative for cognitive decline, positive for functional decline
3. Positive for cognitive decline, negative for functional decline
4. Positive for cognitive decline, positive for functional decline

Interpret the results

Mrs. Pérez is POSITIVE on her Cognitive Health Assessment.

1. Positive symptoms
2. Positive (abnormal) on cognitive screening tool
3. Negative (normal) on functional screening tool
4. (Documented care partner information)

Disclose this to her.

Mrs. Pérez: Documentation

In your note:

- History: Reported more forgetting to pick up her grandson
- Exam: GP-COG part 1 4/9 (positive) and part 2 4/6 (negative)
  - Informant: daughter, Ana
  - Interpretation: negative screen for dementia at this time
- Support system: Ana *last name*, daughter, *contact information*
  - Does not have health care agent designated
- GP-COG result disclosed to patient, plan for annual screening and brain health plan

**

Disclosure

You inform Mrs. Pérez that her GP-COG was positive for possible decline in her cognitive abilities, but her ability to do her daily activities is not affected. You want to continue to do some evaluation though given that she has some symptoms (her screen is positive).

1. "Mrs. Pérez, what is your understanding of the assessment so far?"

1. "What questions do either of you have so far about the assessment?"

Documentation

What Documentation Is Required for Billing?

Billing can occur for 1494F if the provider documents all of the following:

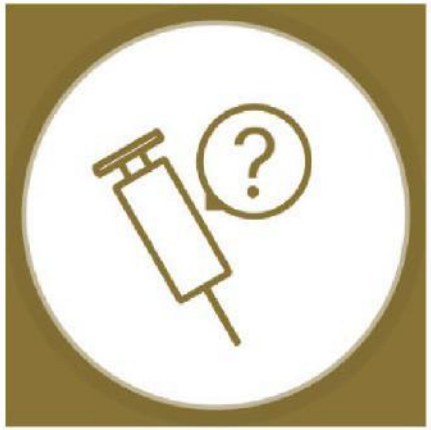
1. The screening tool or tools that were used (at least one cognitive screening tool is required in order to bill this code).
2. That the completed assessments were reviewed by the provider.
3. The results of the assessment(s).
4. The interpretation of the results.
5. That the results were discussed with the member, family, or informant, and any appropriate actions were taken.

DEMENTIA Care Aware

Documentation must remain in the patient's medical record and be available upon request.

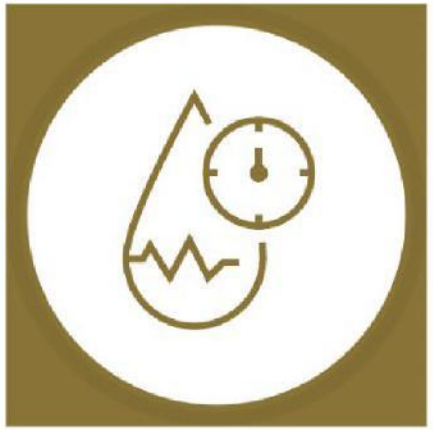
After a positive cognitive health assessment: Start a brain health plan

Make sure vision and hearing assessments are up to date and, if impairments are present, correct them accordingly.



Review medication for cognitive side effects and reduce as many of these as you can in dose or frequency, and preferably stop them. Some common medications with cognitive side effects are listed below.

Encourage social and physical activity.



Continue to address blood pressure and diabetes management goals.

After a positive cognitive health assessment: Plan for a visit to start the next steps in the workup

DEMENTIA Care Aware

Tip: Utilize Your Team

Different members of the team can contribute to the CHA. For example, the front desk staff might notice that a patient is missing more appointments, or a medical assistant might alert a provider that a patient has been repeating themselves or coming to appointments on the wrong day.

Thank You!

For more information please contact:

ucigeriatrics@hs .uci.edu

UCI Division of Geriatric Medicine and Gerontology

DEMENTIA Care Aware
Early detection. Better care.

UCSF

DHCS

UC Irvine ECHO Series

Age Friendly Geriatrics Education

- Every other Wednesday and every Friday at the lunch hour (12-1PM PST)
- Multitude of topics in relation to Geriatrics, with a new topic every other Wednesday
- Open to all specialties, Nurse Practitioners, Physician Assistants, etc.
- Free CME/CE/CEU's per session!!!

Scan the QR code on flyer to register for our series

Alzheimer's Los Angeles
Until there's a cure, we'll provide the care

Helpline: 844.435.7259 available for information, emotional support, local resources, and referrals

Care Consultation: guidance, support, and dementia expertise from experienced social workers

Support Groups: share information and understanding with other caregivers or others living with dementia

Activity Programs: activities that focus on arts, music, cognitive stimulation, and socialization

Disease Education & Caregiver Workshops: classes, tip sheets, and videos about Alzheimer's disease, dementia, brain health, and caregiving

ALZ Direct Connect® Referral Program


Alzheimer's LOS ANGELES

ALZ DIRECT CONNECT

REFERRAL PROGRAM

Partnering with healthcare and aging service providers to improve care and support for people with Alzheimer's or dementias & their families

ALZ DIRECT CONNECT allows healthcare and aging services providers to directly link patients/clients and families to Alzheimer's Los Angeles for:

- access to care coordination & psychosocial support
- referrals to supportive services
- help with understanding the disease & navigating its progression
- a 360 approach to care through feedback to the referring provider

HELPS families understand Alzheimer's & other dementias

CONNECTS families to resources & education

IMPROVES coordinated care & builds supportive networks

844.HELP.ALZ • AlzheimersLA.org

ALZ DIRECT CONNECT does not fulfill mandatory legal reporting requirements for healthcare professionals. Alzheimer's Los Angeles maintains high professional & ethical standards for care & safety and therefore reports any and all allegations or suspicions of elder abuse and/or child abuse.

See reverse side for ALZ Direct Connect Referral Form

Helps: patients & families understand Alzheimer's and dementia

Connects: families to local resources, support, and education

Improves: care coordination

www.alzheimersla.org/alzdirectconnect

Connect with us today to support your families

Eddy Moreno

Director, Clinical Outreach

EddyMoreno@alzla.org

Questions