Diagnosis and Management of Dementia in the Primary Care Setting

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Objectives

• Describe the recommended approach to cognitive assessment at the Annual Wellness Visit
• Know when and how to administer the mini-Cog and MoCA, how to access MyLearning training on these tools, and where to find these forms in iCentra
• Understand how to evaluate cognitive impairment and make a diagnosis of dementia
• Be familiar with the criteria for the diagnosis of Alzheimer’s disease and vascular dementia
Why do cognitive assessments?

- Utah will experience a 127% increase in prevalence of dementia
- 50% of cases are undiagnosed
- While there is no cure, interventions have been shown to
  - Prolong independence at home
  - Decrease cost of care
  - Improve patient quality of life
  - Improve caregiver health
What is dementia?

- A syndrome of cognitive impairment in two or more domains (for example: problem solving, memory, language) that is
  - Progressive AND
  - Is not due to another medical or psychiatric cause AND
  - Causes decline in ability to carry out responsibilities and live independently
- The diagnosis of dementia is based primarily on the patient's history and exam
- The most common cause (BY FAR) is Alzheimer’s disease
- Vascular disease, Lewy Body Disease, Parkinson’s Disease, Frontotemporal Dementia, Normal Pressure Hydrocephalus are other causes
## Difference between Mild Cognitive Impairment and Dementia and Relevant Screening Tool

<table>
<thead>
<tr>
<th></th>
<th>Mild cognitive impairment</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive impairment</td>
<td>• Decline from previous level</td>
<td>• SAME</td>
</tr>
<tr>
<td></td>
<td>• Not due to delirium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not due to another diagnosis</td>
<td></td>
</tr>
<tr>
<td>Functional impact</td>
<td>Cognitive deficits do not interfere with IADLs</td>
<td>Cognitive deficits interfere with IADLs</td>
</tr>
<tr>
<td>Screening tool</td>
<td>MoCA</td>
<td>Mini-Cog</td>
</tr>
</tbody>
</table>
MiniCog

- 2-3 minutes to administer
  - 3 item recall
  - Clock draw
- Possible score 0-5:
  - ≤2: Impaired
  - >2: Not impaired
- Recommended for use at the Annual Wellness Visit
MoCA (Montreal Cognitive Assessment)

- 20 minutes to administer
- Sensitive to Mild Cognitive Impairment
- Available in many languages and sight impaired
- Assessment of memory complaint OR follow up to abnormal MiniCog
MyLearning MiniCog and MoCA training

- 12 minute training
- Appropriate for Care Managers, Medical Assistants, Providers
- Search for MiniCog on MyLearning to access (instructions in your packet)
Icentra: MA to MD workflow on Medicare AWV
PCP Workflow
Diagnosis of the Dementia Syndrome

**ALGORITHM: DEMENTIA DIAGNOSIS**

**COGNITIVE CONCERN OR ANNUAL WELLNESS VISIT (AWV) — If cognitive concern, add to problem list—Code R41.9**

- ADMINISTER MiniCog cognitive screening
  - < 3
    - Delirium present? See DSM V criteria (a)
    - no
      - MAKE appt with patient AND caregiver to address cognition (b)
    - yes
      - ≥ 3
        - FIND and TREAT cause of delirium. Add to problem list—Code R41.0
        - RE-EVALUATE in 1–2 weeks. If delirium not resolved, refer to Neurology (c).
PRE-APPT (MA/CM)

- **ADMINISTER MoCA** cognitive screening to patient alone while caregiver completes **FAQ** and **Stress Thermometer** surveys in separate room.
- **SCORE** MoCA, FAQ, and Stress Thermometer and give to PCP for appt.

MoCA score < 26? OR red flags? (d)

- **RULE-OUT** non-dementia causes of impairment
  - **CONDUCT** History and physical (e), **ORDER** Labs (f), and **RECONCILE** med list (g) with Pharm D consult if available

- **ADDRESS** any findings
  - If depression or behavioral disturbance
  - If uncontrolled illness or deficiency
  - If medication side effects or reactions

- CONSIDER MHI referral (h) if:
  - Depression ≥ moderate OR
  - Behavioral disturbance present

- **TREAT** and **RE-EVALUATE** in 1–4 weeks
Medication reconciliation is critically important

*Patients/caregivers MUST bring prescription and OTC medications and any supplements in BOTTLES*
Indications for Referral to Mental Health

- New onset behavioral disturbance
- Late onset psychosis
- Moderate to severe depression
- Preexisting psychiatric diagnosis that has been exacerbated by impairment
- Coexisting substance dependence
- Emotional adjustment to cognitive impairment
PRE-APPT (MA/CM)

- ADMINISTER MoCA cognitive screening to patient alone while caregiver completes FAQ and Stress Thermometer surveys in separate room.
- SCORE MoCA, FAQ, and Stress Thermometer and give to PCP for appt.

MoCA score < 26? OR red flags? (d)

yes

no

RULE-OUT non-dementia causes of impairment

- CONDUCT History and physical (e), ORDER Labs (f), and RECONCILE med list (g) with Pharm D consult if available

ADDRESS any findings

- If depression or behavioral disturbance
- If uncontrolled illness or deficiency
- If medication side effects or reactions

CONSIDER MHI referral (h) if:
- Depression ≥ moderate OR
- Behavioral disturbance present

TREAT and RE-EVALUATE in 1–4 weeks
Diagnosis of the Dementia Syndrome

Cognitive impairment remaining?  
- yes  
  Red flags remaining (d)?  
    - yes  
      - ORDER brain imaging (i)  
      - REFER to Neurology (c)  
    - no  
      - no  
        - COUNSEL on brain health  
        - RE-EVALUATE annually

PCP Visit 1-3

Functional status (based on FAQ result):

<table>
<thead>
<tr>
<th>Function impaired</th>
<th>Function status unclear</th>
<th>Function not impaired</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORDER brain imaging (i)</td>
<td>REFER to Neuropsychology (j)</td>
<td>DIAGNOSE mild cognitive impairment (MCI) and educate on brain health</td>
</tr>
</tbody>
</table>

Add to problem list — Code G31.84

PCP Visit 2-4

DIAGNOSE dementia (k)
- Without behavioral disturbance — Add to problem list — Code F03.90 OR
- With behavioral disturbance — Add to problem list — Code F03.91
DEMENTIA

An “umbrella” term used to describe a range of symptoms associated with cognitive impairment.

ALZHEIMER’S 50%-75%

VASCULAR 20%-30%

LEWY BODIES 10%-25%

FRONTOTEMPORAL 10%-15%

MIXED DEMENTIA = >1 NEUROPATHOLOGY - PREVALENCE UNKNOWN
# Making a Diagnosis of Dementia Etiology

## Criteria for diagnosis of most common causes of dementia

<table>
<thead>
<tr>
<th></th>
<th>Alzheimer’s disease</th>
<th>Vascular Dementia</th>
<th>Mixed Dementia</th>
<th>Dementia with Lewy Bodies</th>
<th>Frontotemporal Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD 10 codes</strong></td>
<td>G 30.1 &amp; F02.80 or F02.81</td>
<td>F01.50 or F01.51</td>
<td>Code predominant etiology first</td>
<td>G31.83 &amp; F02.80 or F02.81</td>
<td>G31.09 &amp; F02.80 or F02.81, consider Z55.65 or 91</td>
</tr>
<tr>
<td><strong>Clinical Features</strong></td>
<td>Gradual onset of symptoms over months to YEARS</td>
<td>Stepwise decline</td>
<td>Criteria for multiple dementia syndrome etiologies are met. Most common is mixed vascular and Alzheimer’s.</td>
<td></td>
<td>2 of 3 required</td>
</tr>
<tr>
<td></td>
<td>Most prominent features is memory</td>
<td>History of clinically apparent stroke that is temporally related to cognitive decline</td>
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<tr>
<td></td>
<td>Impaired learning and recall of recently learned information</td>
<td>Parkinsonism (bradykinesia, muscular rigidity, tremor, postural instability)</td>
<td></td>
<td></td>
<td>3 of 6 required</td>
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## Stage of Dementia: Based on Patients Functional Status

<table>
<thead>
<tr>
<th>IADL or ADL</th>
<th>Functional status by dementia stage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MCI</td>
</tr>
<tr>
<td>Able to pay bills, balance checkbook independently</td>
<td>Yes with some difficulty</td>
</tr>
<tr>
<td>Able to shop for groceries or clothes alone</td>
<td>Yes</td>
</tr>
<tr>
<td>Able to bathe, dress, toilet self</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Non pharmacologic treatment of dementia

- Patient and caregiver education
- Caregiver support: Alzheimer’s hotline, area Agency on Aging
- Safety: driving, wandering, fall risk
- Advanced care planning
Caregiver support

- Supporting caregivers improves health and quality of life for patients
- Caregivers are also our patients! Caregiver support improves health of caregivers
- Educate about the disease and connect patient/family to local and national resources
- Provide guidance on safety, driving, agitation, and help family plan for need for increased supervision as dementia progresses
ALGORITHM: PHARMACOLOGIC TREATMENT OF DEMENTIA

DEMENTIA DIAGNOSED

BEGIN non-pharmacologic treatment (see care plan guideline)
DISCUSS pharmacologic treatment

PRESCRIBE medications by dementia type
(See CPM medication tables for dosing and details about specific medications)

<table>
<thead>
<tr>
<th>Alzheimer's disease</th>
<th>Vascular and mixed dementias</th>
<th>Fronto-temporal, Lewy-Body, and Parkinson's Dementias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate/severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Donepezil</td>
<td>• Aspirin (unless contraindicated)</td>
<td>• Refer to Neurology</td>
</tr>
<tr>
<td>• Add memantine</td>
<td>• Treat vascular risk factors as appropriate (hypertension, diabetes, high cholesterol)</td>
<td>• Avoid antipsychotics in Lewy-body and Parkinson's dementias (if anti-psychotic needed, choose seroquel at lowest possible dose (12.5 mg QHS))</td>
</tr>
</tbody>
</table>

ASSESS medication and adjust dosing as necessary at each follow-up appointment
Behavioral disturbance

• Environmental modification and education of caregivers on managing agitation has proven effectiveness
• There is no FDA approved medication for agitation in dementia
• There is some evidence that citalopram is helpful
• Antipsychotics have a high side effect profile and are not recommended as first line treatment
Objectives

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Take home points

1. The MiniCog is the recommended cognitive assessment for use at the Annual Wellness Visit. A score of **2 or less** requires further testing and follow up.

2. Dementia is a **syndrome** with many etiologies—the most common cause by far is Alzheimer's disease followed by Vascular Dementia and Alzheimer’s/Vascular Dementia combined.

3. Dementia is diagnosed by cognitive impairment in multiple domains which is **NOT** explained by medical or psychiatric causes **AND** which impacts patients ability to function independently. **An informant** is needed to complete an accurate functional assessment. It is not diagnosed by a lab test, an imaging study or by MoCA score alone.
Take home points

• While there are some medications that can slow the progression of dementia in some patients, the **cornerstone** of treatment for all dementia syndromes is caregiver support and non-pharmacologic interventions.

• A diagnosis of Alzheimer’s disease is made when cognitive decline has a gradual onset and slowly progressive course and the most prominent deficit is in recall of recently learned information.

• A diagnosis of Vascular Dementia is made when there is history of a clinically apparent stroke that is temporally related to cognitive decline.
Resources

• Cognitive Impairment and Dementia Care Process Model coming this fall
• Alzheimer's Disease Education and Referral (ADEAR) Center: https://www.nia.nih.gov/alzheimers
• Alzheimer’s Association: http://www.alz.org/care/
• 24-hour support line: 1-800-272-3900
• Department of Aging and Family Services:
  – Weber Area Agency on Aging: 801-625-3770
• Family Caregiver Alliance: caregiver.org
• Robert.Hoesch@imail.org for questions about Neurology referrals
• Meg.Skibitsky@imail.org if you have questions about the care process model or would like training for your clinic