Early Recognition of Cognitive Impairment:
If you do not ask – they will not tell

Temple Family Practice Review Course

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The premise

• Our current medical system regularly misses/ignores evidence of cognitive impairment

• Regular cognitive testing/screening should be completed on adults over 65

• Additional scrutiny should be applied during times of illness and healthcare decline
We are missing crucial transitions in the lives of our patients

Study of > 7000 people > 65 yo:
• Almost half of the people with probable dementia were undiagnosed.
• Of those with probable dementia: 21-37% were still driving, preparing hot meals, managing their own finances & medications, and attending doctors' appointments alone

*Journal of the American Geriatrics Society*, Potentially Unsafe Activities and Living Conditions of Older Adults with Dementia; DOI: 10.1111/jgs.14164
What excuses keep us from testing?

- We don’t have any current great dementia treatment meds – why bother?
- It will make my patient fearful
- It will make my patient annoyed at me
- It takes time
- What do I even do with the cognitive testing results?
Answers to our excuses

• We have focused too much on “cure”. There are clearly benefits beyond treatment alone

• When done carefully, patients are rarely fearful or annoyed, but rather impressed by your comprehensiveness

• Yes, it takes time, but there can be shortcuts

• Our greatest gifts to our patients are not cures, but rather preparation and understanding for what is to come.

• Usually the patient and/or family of the individual with dementia is acutely aware of the clinical changes – they will be relieved by you taking this seriously
16 Benefits of early recognition of cognitive impairment

1. Truly evaluate what is occurring - other causes, possible treatment
2. If dementia treatment is utilized – it is more likely to show benefit early in the disease
3. Longer tracking and monitoring of disease allows more accurate diagnosis
4. You can develop your medical care team
5. It names what the patient/family is experiencing and living with - professional monitoring of a condition creates less anxiety than unidentified disease
6. Early diagnosis allows the individual to participate in own legal, financial and long-term care planning
7. The individual can identify and pursue what is most important
8. Individual can tap into appropriate local resources and support
9. You can be a role model for how to live with the disease
10. Safety steps can be put in place to prevent physical, emotional and financial harm
16 Benefits of early recognition of cognitive impairment - continued

11. A missed diagnosis results in individuals making potentially undesired decisions about physical, financial and social resources

12. Emotional and depressive support can be provided if necessary

13. Medical providers are protected from malpractice by making decisions appropriately with someone who has limited decision-making capacity

14. Prevention of hospital related delirium and complications

15. Caregiver burnout can be identified and supported

16. You could participate in dementia research
Did you know?

• Alzheimer’s disease is the second most feared disease (behind cancer) - 22% of Americans collect their most feared disease. The fear is most prevalent among younger adults.

• If Americans showed confusion and memory loss, would they want to know the cause is Alzheimer’s? Yes - 89%. Of people over 60 – 95%

• If a family member showed memory loss, 97% would want to see a medical provider to determine the cause

• BUT - >50% of Americans with Alzheimer’s have not been diagnosed. 45% of those diagnosed with Alzheimer’s and their caregiver are not aware of their diagnosis
Implications for population health/ACO management

- Trickle-down effect of undiagnosed cognitive impairment
- Study - Readmission rates of older adults with CHF
  - Cognitive impairment found in 65% of hospitalized CHF patients ≥ 70
  - Cognitive impairment (Mini-cog <4) associated with significantly higher 30 day readmission

Unrecognized Cognitive Impairment and Its Effect on Heart Failure Readmissions of Elderly Adults.

Incorporating cognitive testing into office flow

- Establish an expectation of annual cognitive screening for individuals > 65 yo
- Establish a workflow – provider, nurse, support staff
- Establish a documentation protocol – where can you find last year’s test
- If cognitive impairment is found – put it on the problem list!
- AWV (annual wellness visit) is a perfect time to do this – and another reason to do AWV
Provide educational and screening material

• Alzheimer’s Association 10 warning signs checklist
  • www.alz.org/national/documents/10_signs_checklist.pdf

• MCI/Alzheimer’s questionnaire – 21 questions answered by spouse/friend/loved one
  • www.helpguide.org/articles/memory/age-related-memory-loss.htm

• Alzheimers “why get checked” discussion
  • http://www.alz.org/alzheimers_disease_why_get_checked.asp
Early dementia is early, subtle, hidden

• Train your head, heart, emotions and intuition to look for early signs
• Follow your intuition
• Don’t shy away from asking
Louise – how good is your dementia radar?
Normal age-related memory changes

• Forgetfulness is **not** synonymous with dementia
• Learning (takes longer), consolidating (more difficult to associate concepts), retrieving (slower)
• Examples:
  • forgetting parts of an experience
  • where you parked the car
  • events from the distant past
  • a person’s name but remembering it later
  • an appointment
  • why you walked into a room
  • delayed recollection of a phone number

• Most older adults have the ability to remember and describe incidents of forgetfulness
Red flags of cognitive change

• Completely forgetting an important experience (grandchild’s wedding)
• Impairment of known tasks: how to drive a car, read a book, dressing appropriately, bathing
• Forgetting important recent events
• Forgetting ever having known a particular person
• Consistent confusion or decreased alertness
• Loss of organizational abilities - paying bills, car maintenance, schedule details
• Getting lost in familiar places - finding your house on the street
• Repetitive phrases and stories in the same conversation
• New loss of judgment or social appropriateness
• Difficulty making ordinary choices
• Often people with Alzheimer’s do not realize there is a problem, but friends/relatives readily identify concern
Brief screening tools

• Mini-Cog – 2-4 minutes, sensitivity 76%, specificity 89%
  • Three item recall plus clock drawing
  • Score:
    • One point for each correctly recalled word, two points for normal clock drawing
    • 0-2 = high likelihood of dementia
    • 3-5 = low likelihood of dementia
  • [www.alz.org/documents_custom/minicog.pdf](http://www.alz.org/documents_custom/minicog.pdf)
  • Video on administration: [http://www.actonalz.org/node/112](http://www.actonalz.org/node/112)

• Verbal Fluency test - one minute, sensitivity 88%, specificity 97%
  • Name as many animals as possible in 60 seconds
  • Score
    • One point for each unique animal named
    • < 15 is suggestive of dementia (< 12 if 1-7 years education, < 9 if no education)
Cognitive testing

• When screening is abnormal, follow with more in-depth testing

• Mini-Mental State examination (MMSE, Folstein) - 5 to 12 minutes
  • Problematic in accuracy & copyrighted

• MoCA (Montreal Cognitive Assessment)
  • www.mocatest.org
  • Video on administration - http://www.actonalz.org/node/112

• SLUMS (St. Louis University Mental Status)
  • http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf
  • Video on administration - http://www.actonalz.org/node/112
Stages of Alzheimer’s disease (2011 Guidelines)

• Preclinical Alzheimer’s disease
  • Measurable changes in biomarkers
  • May begin years or decades before memory loss and confusion are evident
  • No specific diagnostic criteria, or suggestion for current clinical use
• MCI (mild cognitive impairment) due to Alzheimer’s disease
  • Mild changes in memory/cognitive abilities that can be noticed and measured
  • Does not significantly impair daily activities and function
• Dementia due to Alzheimer’s disease
  • Changes of memory, thinking and behavior that impair daily function
  • Mild/mod/severe, or 7 stages of FAST scale

www.alz.org/health-care-professionals/dementia-diagnosis-diagnostic-tests.asp
Diagnosis delivery

• Here’s where we stand now
• This is a significant diagnosis that may effect your health, but we cannot accurately predict the future. Everyone’s course is unique.
• This is not the end of life as you know it. It is an opportunity to prioritize what is most important to you and your family
• I expect you to remain active, be engaged in life, enjoy your favorite things, and celebrate life with your loved ones
• As your medical provider, I will walk along in your journey, guiding your choices. I will be honest with you and your family, even if it is hard to do so.
• Goals:
  • Maintain quality of life
  • Maximize function in daily activities
  • Enhance cognition, mood and behavior
  • Foster a safe environment
  • Promote social engagement, as appropriate
• Video - http://www.actonalz.org/node/112
Cognition and meds - “What have we done to you lately?”

- **Anticholinergics**
  - Sleep aids – diphenhydramine, “-PM meds”
  - Antiemetics - meclizine, prochlorperazine (Compazine)
  - Anti-histamines - diphenhydramine, promethazine (Phenergan)
  - Anti-Parkinson - benztropine, trihexyphenidyl
  - Antipsychotics - olanzapine, quetiapine
  - Anti-spasmodics - atropine, belladonna, dicyclomine, oxybutynin, tolterodine

- **Muscle relaxers** – cyclobenzaprine, carisoprodal
  - Benzodiazepines - Lorazepam (Ativan), alprazolam (Xanax), valium
  - Hypnotics - zolpidem (Ambien), temazepam (Restoril), OTC sleep aids (diphenhydramine)

- **GI**: cimetidine (Tagamet), famotidine (Pepcid)
- **Antidepressants**: tricyclics, mirtazepine
- **Narcotics**: hydrocodone, oxycodone, tramadol
- **Some statins**: causality not certain
Patient advice

• Lifestyle – physical exercise, routines, brain exercises
• Discussion with loved ones and caregivers
• Advance care planning and legal documents
• Anticipation of high risk settings - hospital delirium
Print/web resources

Alzheimer’s Association  www.alz.org

- Many resources such as suspected AD disease packet, newly diagnosed person with dementia packet, early-stage care partner packet, mid to late stage caregiver packet, AD treatments, driving resources, safety center
- Alzheimer’s personalized action plan – Includes symptoms, safety, driving, legal planning, knowledge, financial planning, care options, daily living - https://www.alzheimersnavigator.org/
- For providers - Alzheimer’s disease pocket card app (free) - differential diagnosis, interactive tools, send education packets directly to patients, etc.
Print/web resources

• National Institute on Aging - www.nia.nih.gov/alzheimers
  • Provider education
  • Caregivers – behaviors, everyday care, communication, relationships, safety, legal/financial issues

• Caregiver’s Guide to Understanding Dementia Behaviors
  • https://www.caregiver.org/caregivers-guide-understanding-dementia-behaviors

• New Approaches for Dealing with Difficult Dementia Behaviors
  • http://www.alzheimers.net/1-6-15-new-approaches-difficult-behaviors
Early cognitive impairment

• Especially with our older patients, our radar should always be on
• Not a "gotcha" approach, but a caring and supportive inquisitiveness
• "Thank you for answering my questions. It helps me provide better care"
• Test regularly and especially when you see the red flags
• When done well, most patients will be very appreciative and more trusting
• You can alleviate many worries, manage your patients more effectively, prevent complications, and receive great professional satisfaction