# Assessment and Diagnosis of Dementia

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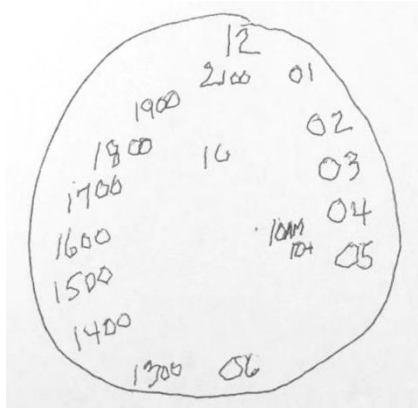
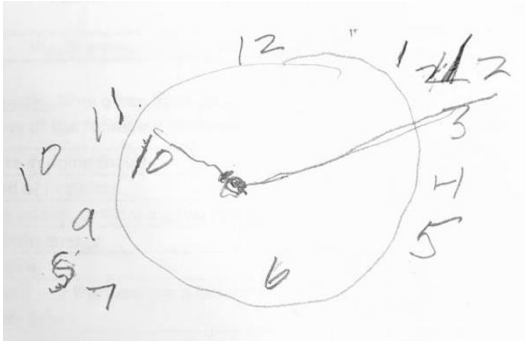
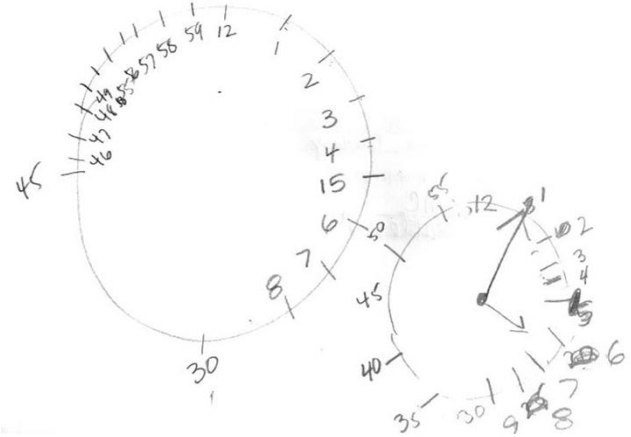
UW Medicine

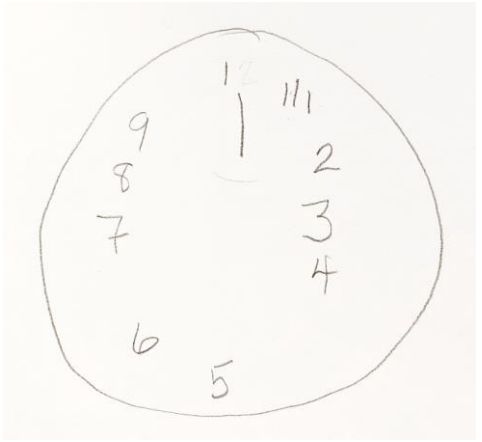
# TODAY'S ROAD MAP

- MCI vs Dementia
- Cognitive Screening
- Resources for Clinicians

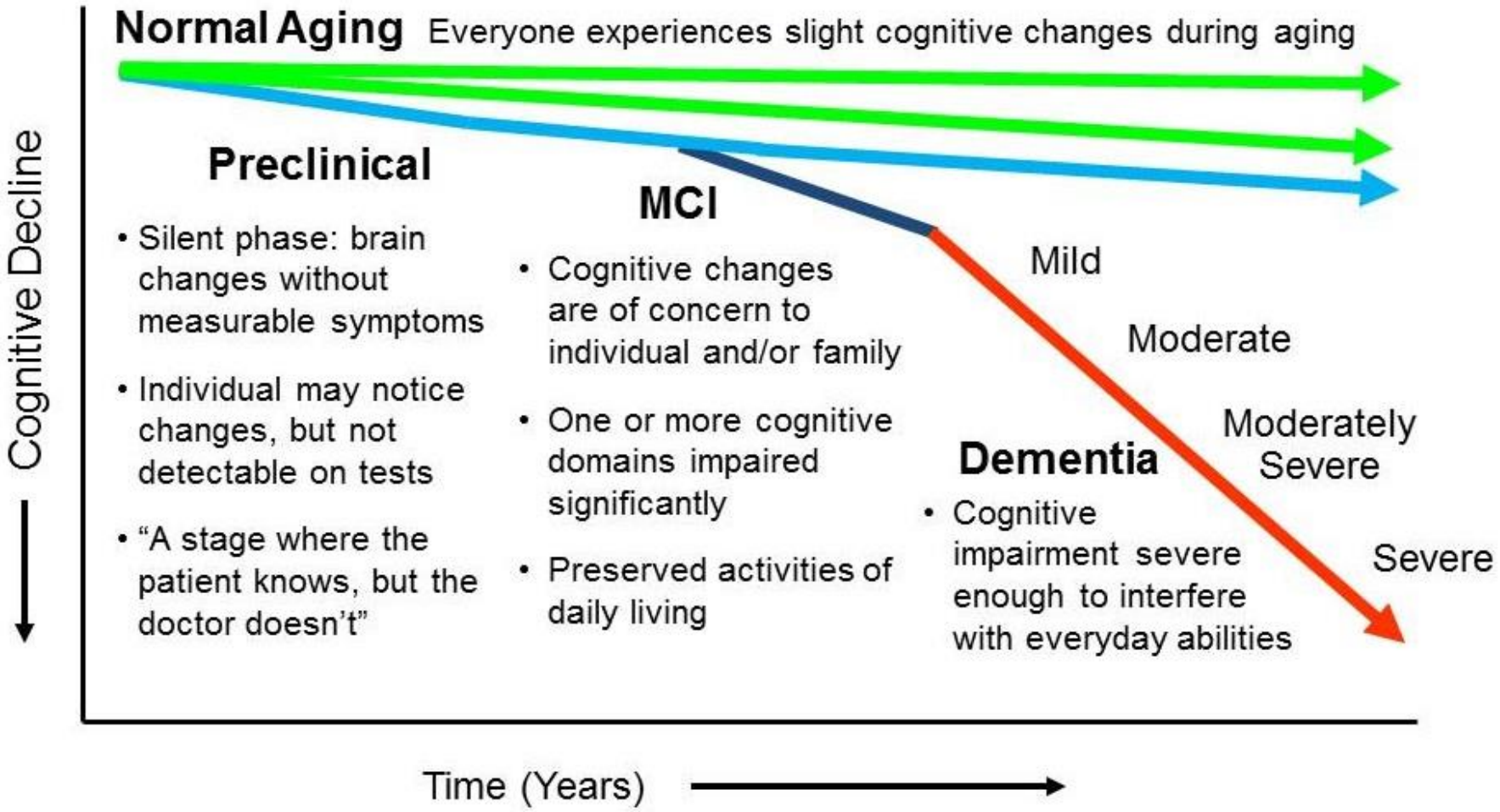








# Cognitive Aging Timeline



# MCI vs. Dementia

## MCI

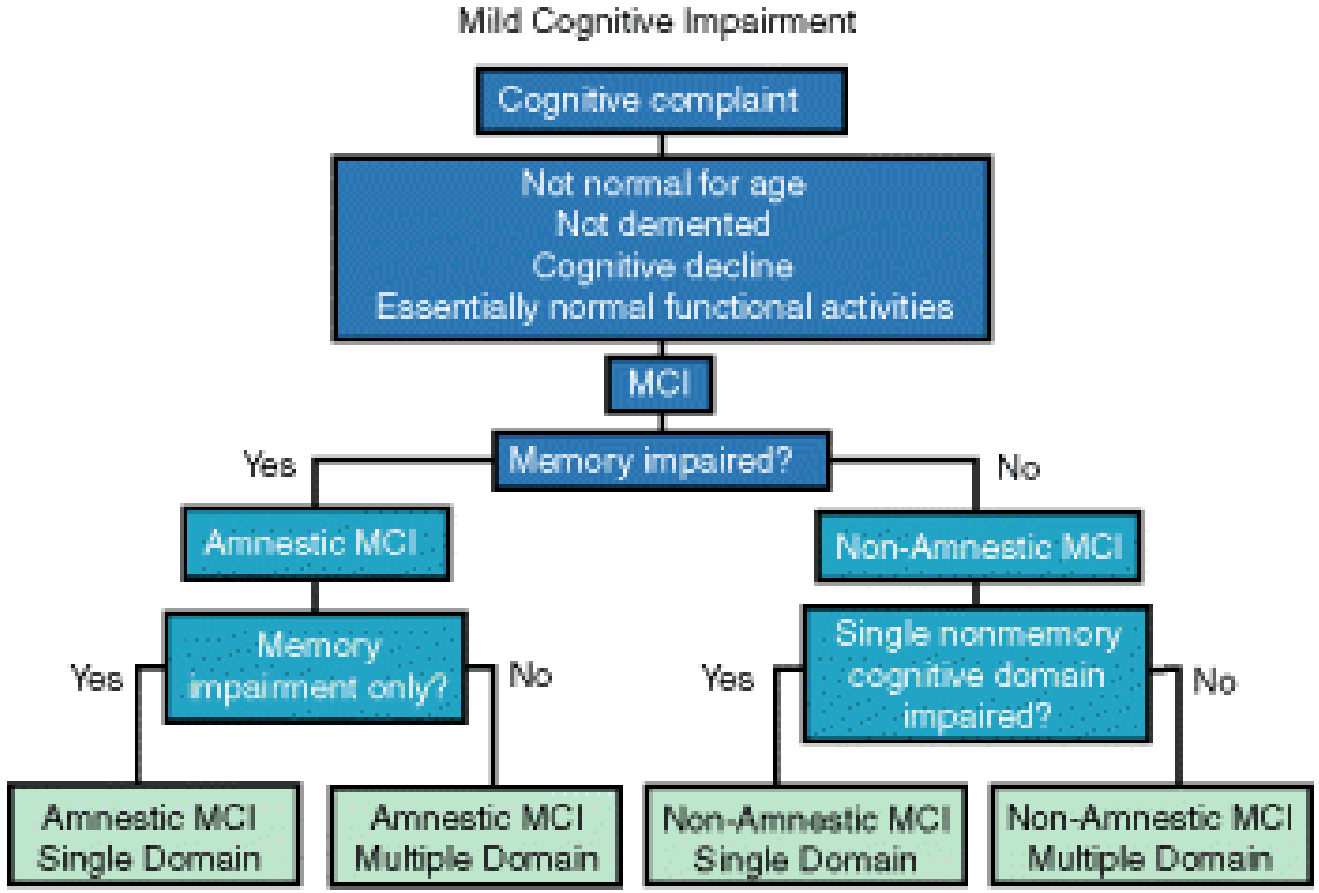
- Mild cognitive change from baseline
- Intact activities of daily living
  - E.g., driving, financial management
  - *May need to use compensatory strategies
- Many different causes
  - MCI is a non-specific diagnosis
  - May or may not be related to neurodegenerative disorder

## Dementia

- Moderate to severe changes from baseline
- Impaired activities of daily living
  - Basic ADLs may be impacted later in disease
- Many different causes
  - Alzheimer's disease, Lewy Body, FTD, etc.

Related ECHO didactics:
10/22/21 – MCI

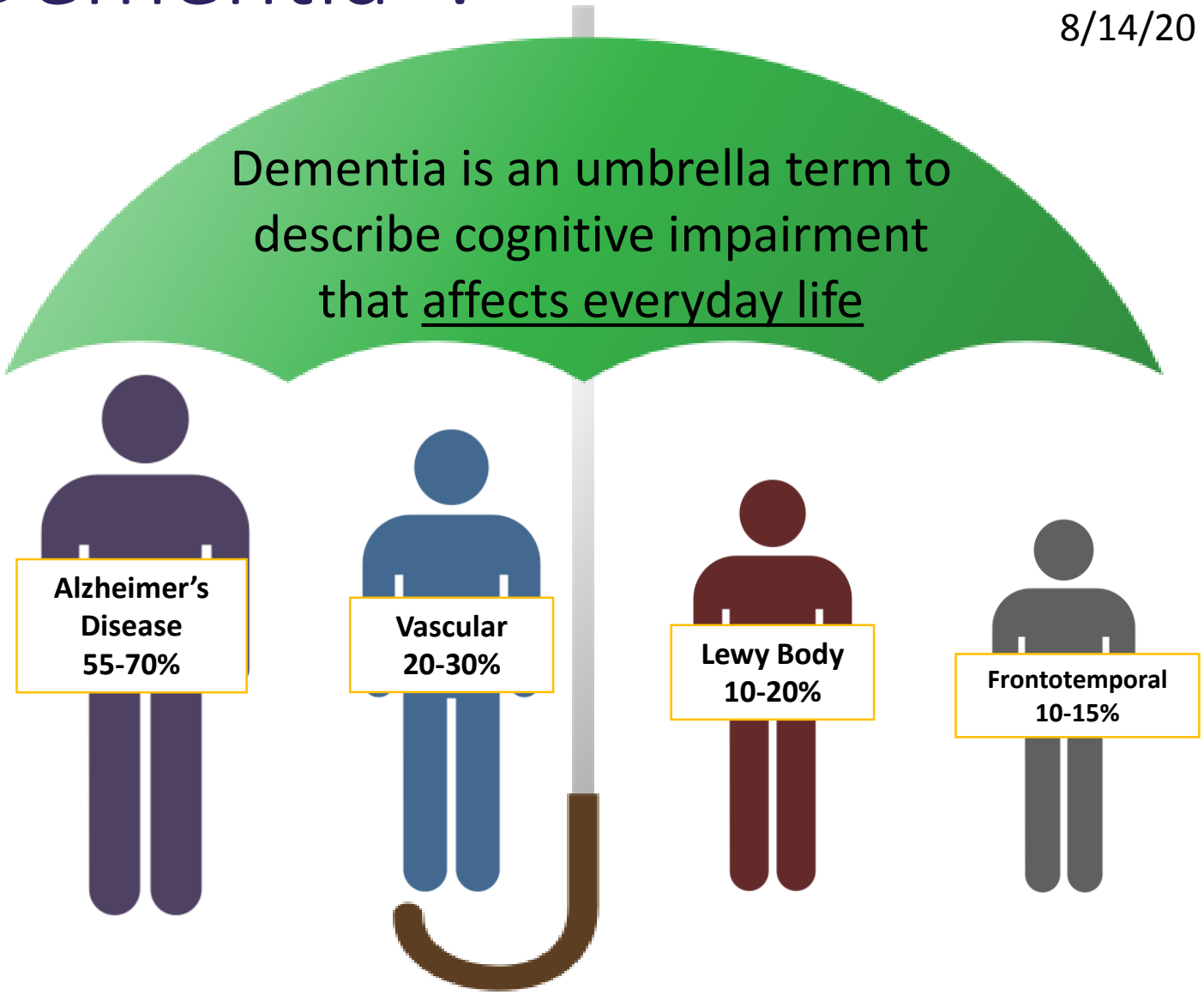
# MCI Diagnostic Flowchart




Petersen et al., 2004; Journal of Internal Medicine, Volume: 256, Issue: 3, Pages: 183-194, DOI: (10.1111/j.1365-2796.2004.01388.x)

# What is “Dementia”?

Related ECHO didactics:
8/13/21 – Overview of FTD
7/23/21 – Overview of DLB
8/14/20 – Dementia Differentials




**Other Causes:**
- **Mixed Dementia**
- **Parkinson’s disease**
- **Huntington’s disease**
- **TBI**
- **Substance Abuse**
- **HIV/”HAND”**

# Cognitive Screening

# Role of Primary Care

Related ECHO didactics:
10/22/21 – MCI
7/20/18 – Detecting Cognitive Decline in Primary Care

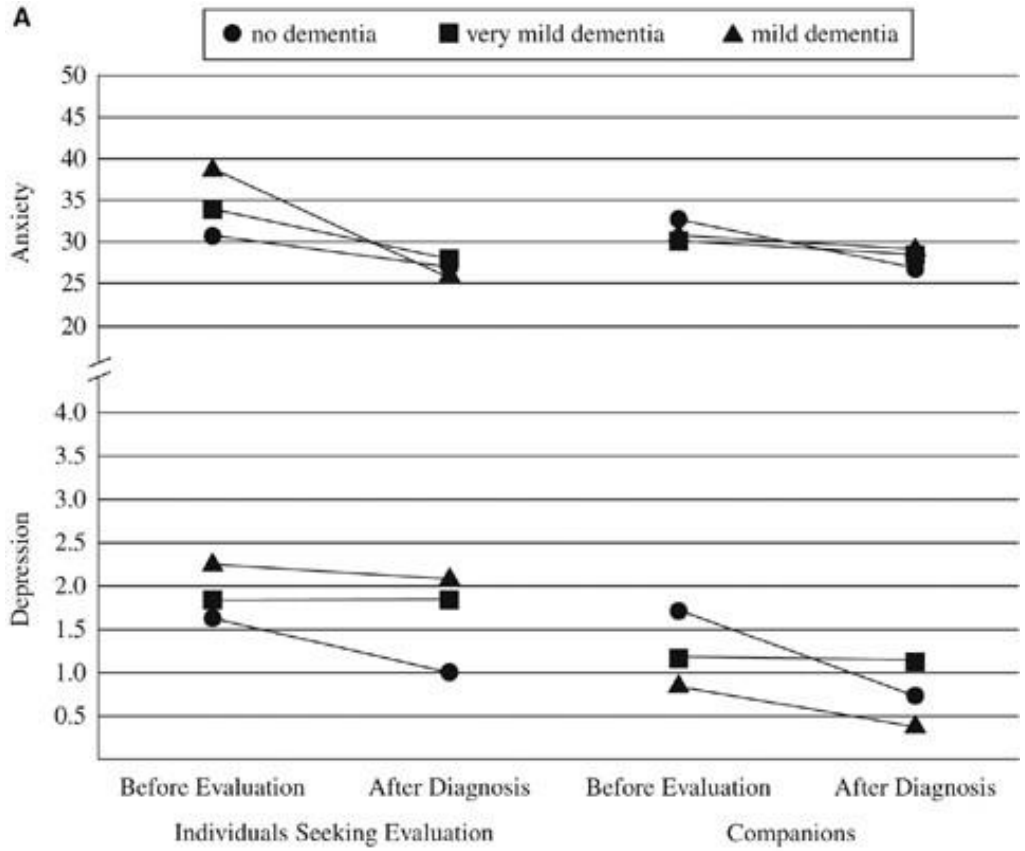
- PCPs are the front lines of dementia care
  - most familiar with the longitudinal health and functioning of their patients
  - BUT less than half of all patients with dementia have diagnosis in their medical record

- Commonly Reported Barriers of Dementia Diagnosis
  - Limited appointment time
  - Unwieldy screening tools
  - Concern of causing more stress or problems for the patient/family
  - “There’s nothing that can be done about it”

# Debunking Myths with Data

**"Diagnosis will increase depression, anxiety, suicidal ideation, etc., in patients"**

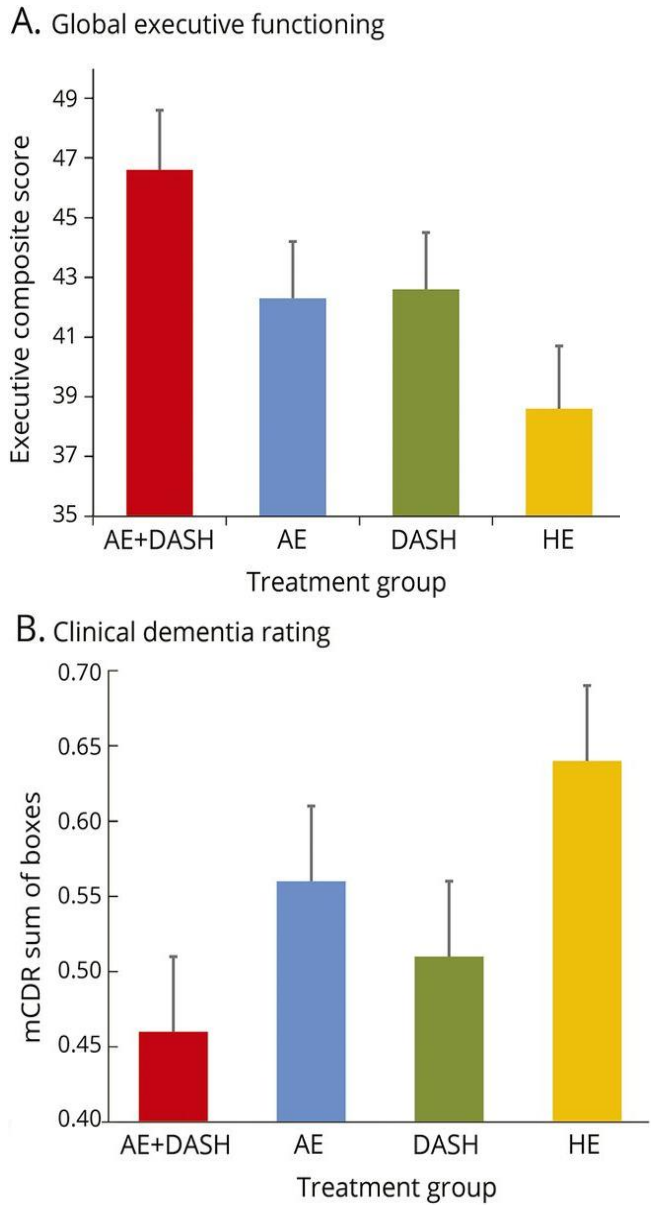
- Carpenter et al. (2008)
  - 90 people with dementia and their care partners
  - Measured depression and anxiety before/after dementia
    diagnosis
  - No significant differences in anxiety or depression, regardless of diagnosis or severity
  - Many reported relief and decreased anxiety afterward



# Debunking Myths with Data

**"Nothing can be done about it, so why bother?"**

- Empirical support for several non-pharmacological interventions that improve emotional wellbeing and quality of life and reduce caregiver burden
- Exercise – moderate exercise for at least 30-45 min, at least 3-4 days per week (Blumenthal et al., 2019; Baker et al., 2010)
- Diet – MIND or Mediterranean (Morris et al., 2015); DASH (Tangney et al 2014))
- Stress reduction, meditation and mindfulness practice




Blumenthal et al., 2019

# Cognitive Screening Tools

- Brief, easy-to-administer, quick to score, cut-off indicators
- Screening to see if further evaluation is necessary
- Examples of Screening Measures
  - Good
    - Mini-Cog
    - General Practitioner Assessment of Cognition (GPCOG)
  - Better
    - Montreal Cognitive Assessment (MoCA)
    - Rowland Universal Dementia Assessment (RUDAS)
    - Mini Mental State Exam (MMSE)

**Table 1. Screening Measures Matrix – Patient and Informant Versions**

| | Elements | Administration time | Who can administer | Training to administer |
|---|---|---|---|---|
| **Screening Measures for Patients** | | | | |
| **GPCOG**<br><br>(See informant version below) | • Memory<br>• Orientation<br>• Aspects of visuospatial and executive **function** | • 2-5 mins for patient | • Medical assistants<br>• Nursing<br>• Providers (MD, ARNP, PhD) | Minimal<br><br>Online administration and training in multiple languages |
| **Mini-Cog** | • Memory<br>• Components of visuospatial and executive function | • 2-3 minutes | • Medical assistants<br>• Nursing<br>• Providers (MD, ARNP, PhD) | Online training available |
| **Memory Impairment Screen** | • Verbal memory only, with greater depth involving free versus cued recall and no demands on writing or motor function | • 4 minutes, half of which is a distractor activity | • Medical assistants<br>• Nursing<br>• Providers (MD, ARNP, PhD) | Minimal training needs |

| Screening measures for care partners or family members | | | | |
|---|---|---|---|---|
| **GPCOG, Informant Version** | • Informant perceptions of cognitive and functional changes | • 2 minutes | • Medical assistants<br>• Nursing<br>• Providers (MD, ARNP, PhD) | Minimal |
| **Family Questionnaire** | • Change in cognition and function | • 2 minutes | Self-administered | Minimal |
| **AD8 Dementia Screening Interview** | • Change in function and activity secondary to cognitive impairment | • 2 minutes | Self-administered Or Interview | Minimal |
| **IQCODE** | • Assesses changes in memory, thinking and planning skills | • 10-15 mins | • Nursing<br>• Providers (MD, ARNP, PhD) | Minimal |

# 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) | | | |

# Cognitive Screening Tools

- Brief, easy-to-administer, quick to score, cut-off indicators
- Screening to see if further evaluation is necessary
- Examples of Screening Measures
  - Good
    - **Mini-Cog**
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  - Better
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    - **Rowland Universal Dementia Scale (RUDAS)**
    - Mini Mental State Exam (MMSE)

# Mini-Cog

- www.mini-cog.com
- Free to use
- 3 minutes to administer
- Screening of Memory and Executive Functioning only
- 10 languages
- Cut-off score of 3/5 points

# 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.

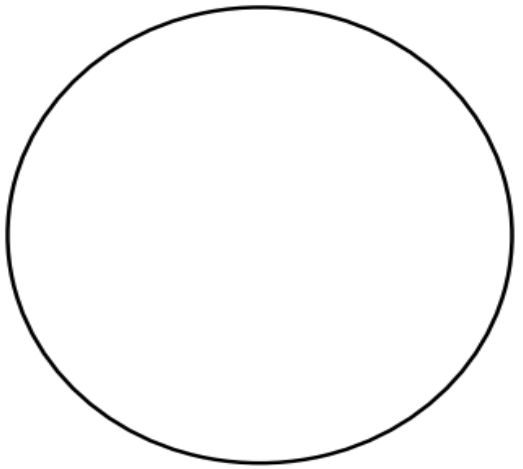
Word List Version: _____ Person's Answers: _____ _____ _____

### 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.<br>Inability or refusal to draw a clock (abnormal) = 0 points. |
| Total Score: _____ (0-5 points) | Total score = Word Recall score + Clock Draw score.<br><br>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: _____

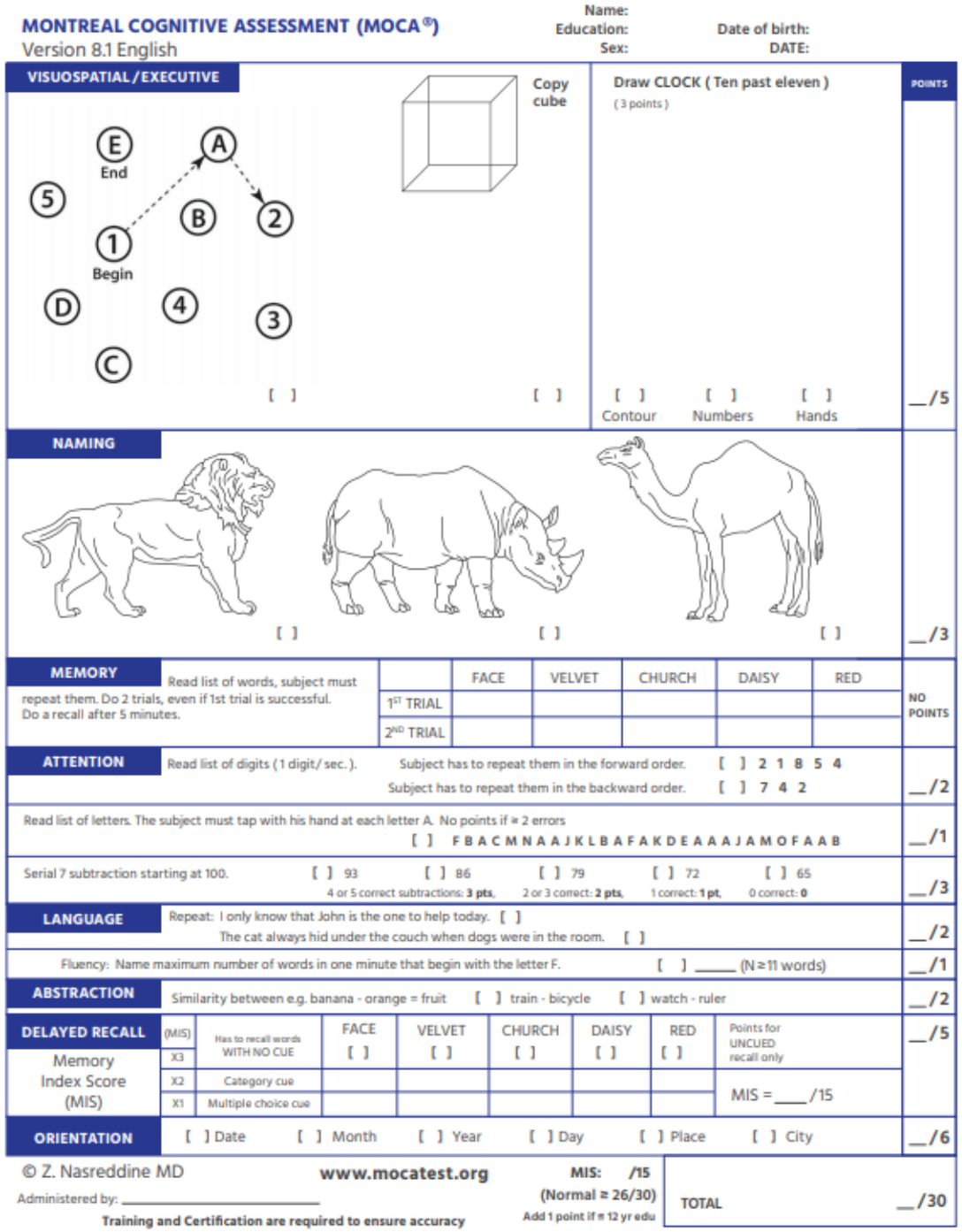


# Montreal Cognitive Assessment (MoCA)

- www.mocatest.org
- Training required – free for academic, research, or students ($150 others)
- Printable instructions to read to the patient
- 10 minutes to administer
- 25+ languages
- Alternate Versions
  - MoCA Basic: low education (<5 years of formal schooling)
  - MoCA Blind: low vision (eliminates vision-dependent subtests)
  - MoCA Mini: 5-minute version

# MoCA

- Screened Domains
  - Executive Function
  - Visuospatial
  - Language
  - Memory
  - Attention
  - Orientation
- Cut-off of 26/30 (“abnormal”)



**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

E End, A, 5, B, 2, 1 Begin, D, 4, 3, C

[ ] [ ]

[ ] 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 |
|---|---|---|---|---|---|
| 1ST TRIAL | | | | | |
| 2ND TRIAL | | | | | |

NO POINTS

**ATTENTION** Read list of digits ( 1 digit/ sec. ). __/2
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

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

Serial 7 subtraction starting at 100. __/3
[ ] 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**

**LANGUAGE** Repeat: I only know that John is the one to help today. [ ] __/2
The cat always hid under the couch when dogs were in the room. [ ]

Fluency: Name maximum number of words in one minute that begin with the letter F. [ ] _____ (N ≥ 11 words) __/1

**ABSTRACTION** Similarity between e.g. banana - orange = fruit [ ] train - bicycle [ ] watch - ruler __/2

**DELAYED RECALL** Memory Index Score (MIS) __/5

| | | FACE | VELVET | CHURCH | DAISY | RED |
|---|---|---|---|---|---|---|
| (MIS) X3 | Has to recall words WITH NO CUE | [ ] | [ ] | [ ] | [ ] | [ ] |
| X2 | Category cue | | | | | |
| X1 | Multiple choice cue | | | | | |

Points for UNCUED recall only
MIS = ____/15

**ORIENTATION** [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

© Z. Nasreddine MD **www.mocatest.org**

**MIS: /15**
**(Normal ≥ 26/30)**
Add 1 point if ≤ 12 yr edu

**TOTAL** __/30

Administered by: _____
**Training and Certification are required to ensure accuracy**

# Memory Index Score (MIS)

| DELAYED RECALL | (MIS) | | FACE | VELVET | CHURCH | DAISY | RED | Points for UNCUED recall only | /5 |
|---|---|---|---|---|---|---|---|---|---|
| Memory Index Score (MIS) | X3 | Has to recall words WITH NO CUE | [ ] | [ ] | [ ] | [ ] | [ ] | | |
| | X2 | Category cue | | | | | | MIS = ____ /15 | |
| | X1 | Multiple choice cue | | | | | | | |

**Montreal Cognitive Assessment Memory Index Score (MoCA-MIS) as a Predictor of Conversion from Mild Cognitive Impairment to Alzheimer's Disease**

*Parunyou Julayanont, MD,[a,b] Mélanie Brousseau, SWT,[a] Howard Chertkow, MD,[c,d,e] Natalie Phillips, PhD,[c,f] and Ziad S. Nasreddine, MD[a,d]*

JAGS 62:679–684, 2014


Lower MIS scores = higher likelihood of conversion from MCI → AD

# RUDAS

- 10 minutes
- Free
- Languages
  - English
  - Chinese
  - Italian
- Training and administration info online
- 25-26/30 cut off

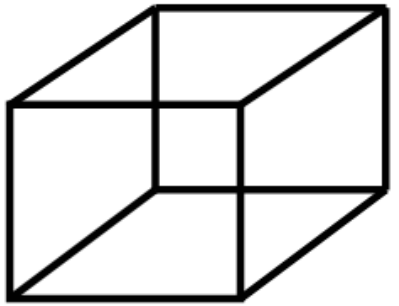
**R U D A S**

**The Rowland Universal Dementia Assessment Scale: A Multicultural Cognitive Assessment Scale.**
**(Storey, Rowland, Basic, Conforti & Dickson, 2004). International Psychogeriatrics, 16 (1), 13-31**

**Date:** ____/____/____ Patient **Name:** _____

| Item | | Max Score |
|---|---|---|
| **Memory**<br>1. (Instructions) I want you to imagine that we are going shopping. Here is a list of grocery items. I would like you to remember the following items which we need to get from the shop. When we get to the shop in about 5 mins. time I will ask you what it is that we have to buy. You must remember the list for me.<br>**Tea, Cooking Oil, Eggs, Soap** Please repeat this list for me (ask person to repeat the list 3 times). (If person did not repeat all four words, repeat the list until the person has learned them and can repeat them, or, up to a maximum of five times.) | | |
| **Visuospatial Orientation**<br>2. I am going to ask you to identify/show me different parts of the body. *(Correct = 1)*. Once the person correctly answers 5 parts of this question, do not continue as the maximum score is 5. | | |
| (1) show me your right foot | .....1 | |
| (2) show me your left hand | .....1 | |
| (3) with your right hand touch your left shoulder | .....1 | |
| (4) with your left hand touch your right ear | .....1 | |
| (5) which is (indicate/point to) my left knee | .....1 | |
| (6) which is (indicate/point to) my right elbow | .....1 | |
| (7) with your right hand indicate/point to my left eye | .....1 | |
| (8) with your left hand indicate/point to my left foot | .....1 | ..../5 |
| **Praxis**<br>3. I am going to show you an action/exercise with my hands. I want you to watch me and copy what I do. Copy me when I do this . . . (One hand in fist, the other palm down on table - alternate simultaneously.) Now do it with me: Now I would like you to keep doing this action at this pace until I tell you to stop - approximately 10 seconds. (Demonstrate at moderate walking pace).<br>Score as:<br>*Normal* = 2 *(very few if any errors; self-corrected, progressively better; good maintenance; only very slight lack of synchrony between hands)*<br>*Partially Adequate* = 1 *(noticeable errors with some attempt to self-correct; some attempt at maintenance; poor synchrony)*<br>*Failed* = 0 *(cannot do the task; no maintenance; no attempt whatsoever)* | | ..../2 |
| **Visuoconstructional Drawing**<br>4. Please draw this picture exactly as it looks to you (Show cube on back of page). *(Yes = 1)*<br>Score as:<br>(1) Has person drawn a picture based on a square? | .....1 | |
| (2) Do all internal lines appear in person's drawing?  | .....1 | |
| (3) Do all external lines appear in person's drawing?  | .....1 | ..../3 |
| Judgment<br>5. You are standing on the side of a busy street. There is no pedestrian crossing and no traffic lights. Tell me what you would do to get across to the other side of the road **safely**. (If person gives incomplete response that does not address both parts of answer, use prompt: "Is there anything else you would do?") Record exactly what patient says and circle all parts of response which were prompted.<br>.....<br>.....<br>Score as:<br>Did person indicate that they would look for traffic? *(YES = 2;YES PROMPTED = 1; NO = 0)* | .....2 | |
| Did person make any additional safety proposals? *(YES = 2;YES PROMPTED = 1; NO = 0)* | .....2 | ..../4 |

| | | |
|---|---|---|
| **Memory Recall**<br>1. (Recall) We have just arrived at the shop. Can you remember the list of groceries we need to buy?<br>(Prompt: If person cannot recall any of the list, say "The first one was 'tea'." *(Score 2 points each for any item recalled which was not prompted – use only 'tea' as a prompt.)*<br>*Tea* .....2<br>*Cooking Oil* .....2<br>*Eggs* .....2<br>*Soap* .....2 | | ..../8 |
| **Language**<br>6. I am going to time you for one minute. In that one minute, I would like you to tell me the names of as many different animals as you can. We'll see how many different animals you can name in one minute. (Repeat instructions if necessary). Maximum score for this item is 8. If person names 8 new animals in less than one minute there is no need to continue.<br>1. ..... 5. .....<br>2. ..... 6. .....<br>3. ..... 7. .....<br>4. ..... 8. ..... | | ..../8 |
| **TOTAL SCORE =** | | **/30** |



https://www.dementia.org.au/resources/rowland-universal-dementia-assessment-scale-rudas

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# Tips for Better Cognitive Screening

- Check the basics: Hearing & Vision
- Does the patient have concerns? Or only the family?
- Fluctuations in symptoms?
  - Good days/Bad day  or  Worsening sx across the day?
- Does anything make the cognitive sx *better*?

# When to Refer to a Memory Clinic

- Patients who benefit the most
  - Atypical presentation or unusual features (e.g., hallucinations, other neurologic sx)
  - Younger-onset (<65yo) with progressive decline
  - Patient or family requesting a specialist evaluation

- Patients less likely to benefit if
  - Multiple other causes have not been addressed (e.g., alcohol abuse, sleep apnea, polypharmacy, untreated depression)
  - They have had a TBI → Rehab Medicine may be a better clinic
  - They have had a stroke → If no progressive cognitive decline, consider general Neurology or Rehab Medicine

# Preparing for a Memory Clinic Appointment

- Complete a cognitive screening (more helpful if it is scanned in to EHR)
- Screen for TSH, B12, alcohol abuse, depression, sleep apnea, hearing loss
- Ask the patient to bring someone who knows them well
  - Prepare them for a 1-2 hour visit (Memory Clinic intake appointment)
  - If Neuropsych only, 3-4 hour visit

# Resources for Clinicians

Related ECHO didactics:

- 10/8/21 “Resources for Practitioners”
- 8/27/21 “Comprehensive Care Planning”

# Cognitive Assessment Toolkit (Alz Assoc)

- Downloadable PDF
- Screening Tools
  - Mini-Cog
  - GPCOG
  - MIS
- Informant Report Measures
  - Short Form of the Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE)
  - AD8 Dementia Screening Interview

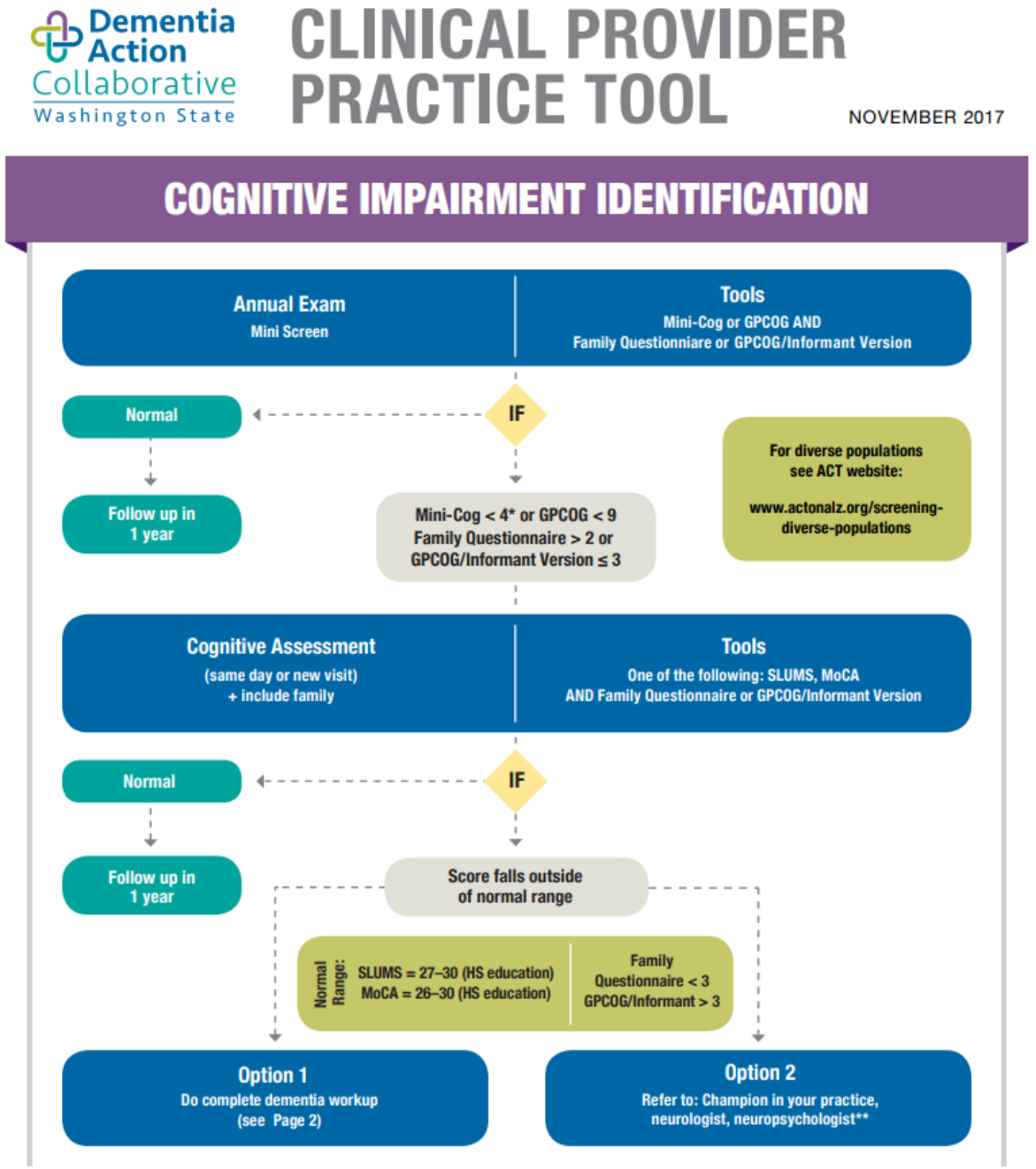

https://www.alz.org/media/Documents/cognitive-assessment-toolkit.pdf

# TOOLS FOR DIAGNOSIS

## Clinical Provider Practice Tool

- 4-page tool for clinical care
  - Diagnosis flowchart
  - Treatment/Management
  - Research-based recommendations and treatment
  - Resources for patients and families

Available as PDF:
https://www.dshs.wa.gov/altsa/dementia-action-collaborative



# DEMENTIA WORK-UP

Follow these diagnostic guidelines in response to patient failure on cognitive screening (e.g., Mini-Cog) or other signs of possible cognitive impairment.

## HISTORY AND PHYSICAL

- Person-centered care includes understanding cultural context in which people are living (see www.actonalz.org/culturally-responsive-resources)
- Assess for hearing and other sensory loss
- Review onset, course, and nature of memory and cognitive deficits (Family Questionnaire may assist) and any associated behavioral, medical, sleep disorder or psychosocial issues
- Assess ADLs and IADLs, including driving and possible medication and financial mismanagement (Functional Activities Questionnaire and/or OT evaluation may assist)
- Conduct structured mental status exam (e.g., MoCA, SLUMS)
- Assess mental health (consider depression, anxiety)
- Assess alcohol and other substance use
- Perform neurological exam focusing on focal/lateralizing signs, vision, including visual fields, and extraocular movements, hearing, speech, gait, coordination, and evidence of involuntary or impaired movements
- The diagnosis conversation and any subsequent conversation follow the ***Alzheimer's Association Principles for a Dignified Diagnosis***[1]

## DIAGNOSTICS

### Lab Tests

- Routine: CBC, lytes, BUN, Cr, Ca, LFTs, glucose
- Dementia screening labs: TSH, B12, Vit. D
- Contingent labs (per patient history): RPR or MHA-TP, HIV, heavy metals

### Neuroimaging

- CT or MRI (with volumetric analysis if possible) when clinically indicated

### Neuropsychological Testing

- Indicated in cases of early or mild symptom presentation, for differential diagnosis, determination of nature and severity of cognitive functioning, and/or development of appropriate treatment plan
- Typically not beneficial in severe impairment (e.g., MoCA < 12)

## DIAGNOSIS*

### Mild Cognitive Impairment

- Mild deficit in one cognitive function: memory, executive, visuospatial, language, attention
- Intact ADLs and IADLs; does not meet criteria for dementia

### Alzheimer's Disease

- Most common type of dementia (60–80% of cases)
- Memory loss, confusion, disorientation, dysnomia, impaired judgment/behavior, apathy/depression

### Dementia With Lewy Bodies/Parkinson's Dementia

- Second most common type of dementia (up to 30% of cases)
- Hallmark symptoms include visual hallucinations, REM sleep disorder, parkinsonism, and significant fluctuations in cognition

### Frontotemporal Dementia

- Third most common type of dementia primarily affecting individuals in their 50s and 60s
- EITHER marked changes in behavior/personality OR language variant (difficulty with speech production or loss of word meaning)

### Vascular Dementia

- Relatively rare in pure form (6-10% of cases)
- Symptoms often overlap with those of AD; frequently there is relative sparing of recognition memory

* The latest DSM-5 manual uses the term "Major Neurocognitive Disorder" for dementia and "Mild Neurocognitive Disorder" for mild cognitive impairment. This ACT on Alzheimer's resource uses the more familiar terminology, as the new terms have yet to be universally adopted.

## FOLLOW-UP DIAGNOSTIC VISIT

**Include family member or care partner at this and subsequent visits**

- Refer to Alzheimer's Association Washington 24/7 Helpline at **800-272-3900** or visit **www.alzwa.org**
- Refer to Community Living Connections (Area Agencies on Aging) at **855-567-0252** or **www.waclc.org/connect**
- Offer the following:
  - ***Living Well: A Guide for Persons with Mild Cognitive Impairment (MCI) & Early Dementia***[2]
  - ***Living with Memory Loss, A Basic Guide*** [UW Medicine][3]
  - ***Dementia Road Map: A Guide for Family and Care Partners***[4]

# DEMENTIA MANAGEMENT

## DIAGNOSTIC UNCERTAINTY & BEHAVIOR MANAGEMENT

### Refer to Specialist as Needed

- Neurologist (dementia focus, if possible)
- Geriatric Psychiatrist
- Geriatrician
- Memory Disorders Clinic

## COUNSELING, EDUCATION, SUPPORT & PLANNING

### Family Meeting

- **Refer to social worker or care coordinator**

### Link to Community Resources

- **Alzheimer's Association Washington** 24/7 Helpline at 800-272-3900 or visit **www.alzwa.org** and/or
- **Community Living Connections** (Area Agencies on Aging) at 855-567-0252 or **www.waclc.org/connect**
- Provide ***Living with Alzheimer's: For People with Alzheimer's Taking Action Workbook***[5]
- Provide ***Living with Memory Loss, A Basic Guide*** [UW Medicine][3]
- Provide ***Dementia Road Map: A Guide for Family and Care Partners***[4]

## STIMULATION, ACTIVITY, MAXIMIZING FUNCTION

### Daily Mental, Physical and Social Activity

- Provide ***Living Well: A Guide for Persons with Mild Cognitive Impairment (MCI) & Early Dementia*** (includes non-pharmacologic approaches for early to mid-stage)[2]
- Provide ***Living with Memory Loss, A Basic Guide*** [UW Medicine][3]
- Adult day services
- Use sensory aids (hearing aids, pocket talker, glasses)

## SAFETY

### Driving

- Counsel on risks
- Refer for driving evaluation[6]
- Provide ***At the Crossroads: Family Conversations About Alzheimer's Disease, Dementia & Driving***[7]

### Medication Management

- Family oversight or health care professional

### Financial / Legal

- Encourage patient to complete a Durable Power of Attorney document; elder law attorney as needed.[8]

### Wandering

- Provide ***MedicAlert® Safe Return*** program information[9]

***Note:*** *Individuals with dementia are vulnerable adults and may be at a higher risk for elder abuse.*

## ADVANCE CARE PLANNING

### Complete Advance Care Plan

- Refer to advance care planning facilitator within system, if available.
- Encourage patient to complete a Durable Power of Attorney Health Care document[10, 11]
- Provide ***Your Conversation Starter Kit: For Families and Loved Ones of People with Alzheimer's Disease or Other Forms of Dementia***[12]

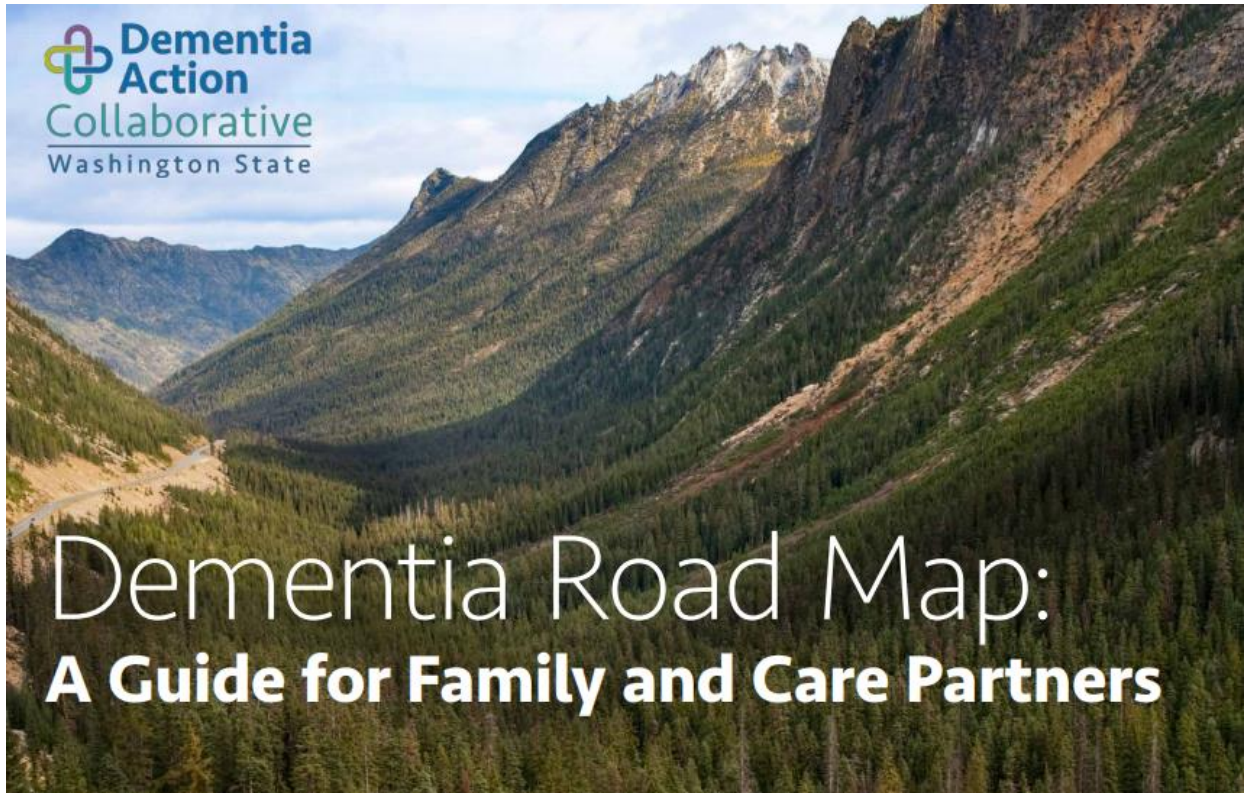
## MEDICATIONS

- Memory: Donepezil, rivastigmine patch, galantamine and memantine (mid-late stage)
- Mood & Behavior: SSRIs or SNRIs
- Avoid/Minimize: Anticholinergics, hypnotics, narcotics, and antipsychotics (not to be used in Lewy Body dementia)

# DEMENTIA ROAD MAP

- Free for providers and families
- Available as PDF online

- Contact DAC for printed copies
  - Send name & mailing address to dementiaroadmap@dshs.wa.gov
  - Also available thru WA chapter of Alzheimer's Association




Dementia Action Collaborative of Washington State

https://www.dshs.wa.gov/altsa/dementia-action-collaborative

# Dementia Road Map: **A Guide for Family and Care Partners**

## CONTENTS



## DEMENTIA ROAD MAP OVERVIEW

### Wondering & Worried

- Is everything OK?
- Should my loved one be checked by a health care professional?
- What if my loved one won't go to a health care professional?

### Mild Cognitive Impairment (MCI)

- Where do we go to get memory loss checked out?
- How can I help my loved one with their memory and thinking?
- What can we do to promote our loved one's well-being?

### Early-Stage Dementia

- Are there any medication, treatments or lifestyle changes that could help my loved one's memory and thinking?
- How can we help our loved one stay active and connected?
- Should my loved one still be driving?
- Is our legal paperwork in order?

### Mid-Stage Dementia

- What can I do to make the home safer?
- What do we do if our loved one won't stop driving?
- Where do we get help in coping with behaviors?
- What services might help and where do I find them?

### Late-Stage Dementia

- What can we do to promote quality of life?
- What kind of care is best for my loved one?
- What do we want in terms of medical care at the end of our loved one's life?



# Early-Stage Dementia

*"We were very fortunate that my parents signed important legal documents and had long-term care insurance in place from the beginning of mom's dementia. These things gave my dad peace of mind after mom could no longer make decisions."*

– **Karen M.**, family caregiver from Seattle

## You may be wondering...

- **Are there any medications, treatments or lifestyle changes that could help my loved one's memory and thinking?**
- **How can we help our loved one stay active and connected?**
- **Should my loved one still be driving?**
- **Is our legal paperwork in order?**

## What should you expect in this stage?

Your loved one has difficulty accomplishing some activities. They may also:

- Have trouble with time or sequence of events.
- Forget names of familiar people and things.
- Have decreased performance in work or social situations.
- Have trouble multi-tasking.
- Take more time to process information.
- Write reminders and lose them.
- Have increased preferences for familiar things.
- Have mild mood and/or personality changes.
- Feel sorrow, suspicion, anger, frustration.
- Show increasing indifference to normal courtesies of life.
- Have more trouble driving safely.

At the same time, you may find that your loved one has some kinds of memory that work quite well: they will likely remember stories from long ago, and remember how to do things that they are familiar with (like playing an instrument). They may be able to focus more on the present moment, enjoy a sense of humor and a growing ability to be creative.

**You may:**

- Feel optimism and/or an early sense of loss and grief.
- Notice a need to provide more reminders and supervision.
- Want to ask for help around the home like housekeeping, errands, laundry, or yard care.
- Be impressed by your loved ones ability to adapt and grow, in the midst of challenges.

## What you can do:

- Be an advocate for the right diagnosis and best health care. If you're not happy with current care, find a health care professional that will work with you and your loved one together.
- Learn all you can about the disease and tips for communicating supportively with your loved one. See ***Communication Tips*** on pg. 23.
- Put safety measures in place before they're needed related to falls, wandering, medication use, harmful cleaning products, guns, power tools, etc. Find information on safety in the ***Resource List*** on pg. 25 – 26.
- Embrace the good days and prepare yourself for the stormy ones.
- Make your life a no guilt zone.
- Keep up health and wellness appointments for yourself.
- Make efforts to get a good night's sleep every night.
- Seek out support and reassurance: talk with others who have had a similar situation (e.g., early memory loss support group) or call the Alzheimer's Association Helpline.
- Explore how your loved one wants to live at the end of their lives. Learn about "having the conversation", through the *"Conversation Starter Kit for Families of Loved Ones of People with Alzheimer's Disease or other Forms of Dementia."* See ***Resource List*** on pg. 25 – 26.
- Encourage your loved one to use the in-depth dementia advance planning legal document in Washington State, *"Alzheimer's and Dementia Mental Health Advance Directive"* to document their wishes about anticipated challenges throughout the progression of the disease (such as when to stop driving, where they want to live, who provides their care). See ***Resource List*** on pg. 25 – 26.

*Continued on next page...*

# Additional Resources

- **Dementia Action Collaborative of Washington State**: https://www.dshs.wa.gov/altsa/dementia-action-collaborative
- **Alzheimer's Association**: www.alz.org
  - https://www.alz.org/professionals/healthcare-professionals/cognitive-assessment

**Support for patients and their families**

- **Alzheimer's Association 24/7 Helpline: 1-800-272-3900**
  - Staffed by counselors and social workers to help your patients and their caregivers with questions and local support resources
- **www.memorylossinfoWA.org**

# QUESTIONS?