Mild Cognitive Impairment

ECHO-Dementia

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Learning Objectives Today

- Communicating a diagnosis of MCI.
- Talking about prognosis for MCI.
- When to refer to a neurologist.
- High value community resources to recommend.
- Value of filling out a DPOA in MCI.

82 year old woman in your office for her Medicare Annual Wellness Visit. Generally very healthy.

Hypertension, osteoarthritis.

Medications: Losartan, rare ibuprofen, rare zolpidem.

She happens to mention, “I‘ve been worried about my memory.”

Key teaching point: ask her to return to see you again two weeks later for a follow-up visit, so you'll have time for a full cognitive evaluation.

Why? In addition to being out of time, she's alone at this Wellness Visit. So you write out for her: "It's essential that a family member comes with you to your next visit."

Ask: "Would it be OK if I reached out to them to help to schedule this?"

At the follow-up cognitive evaluation visit:

Husband reports she often repeats questions and becomes disoriented in familiar surroundings.

Her MOCA score is 23/30.

But.... She’s still fully independent in ADL’s

Diagnosis:
Mild Cognitive Impairment

At the end of this cognitive evaluation visit you next say:

"This is a lot to take in and work through. Let's schedule another visit in 2-3 weeks to review what this means and make a plan."

Now back in your office for a follow-up “Diagnosis Discussion” visit. You’ve scheduled it into a longer appt slot (like the cognitive evaluation visit) and you’ll bill it as a level 5 visit, because…

(**Exciting news:** as of 2021, a Level 5 is now 30% more RVUs than 2020, now double a Level 3. And the 40-minutes needed to get to Level 5 time-based billing is now total time spent on care, not just face to face.)

You’ve encouraged all the family members, that her and her husband want, to come to this visit.

Diagnosis Discussion Checklist

☐ Disclosure and Prognosis

☐ When to Refer to Neurology

☐ Brain Health

☐ Patient and Caregiver Support and Resources

☐ Durable Power of Attorney for HC

What is Mild Cognitive Impairment (MCI)?

- If MoCA is low + observer reports cognitive changes, but person still fully independent in ADLs, then it’s mild cognitive impairment.
- Somewhat mysterious syndrome. Large majority progress to dementia. Maybe about 70%.
- But 30% of people with MCI **don’t** progress.
- A large number have early Alzheimer’s. But not all.

Clin Geriatr Med. 2018 Nov;34(4):563-589

Disclose the Diagnosis

Setting the Stage

- Try to have family there.
- Ask first: "**Is it OK if I share what I think is going on?"** This preps them for bad news. In effect, you're asking "are you ready now?"
- Acknowledge fear. But also share hope, some optimism. "**This is good to know, it will help to be more ready**."
- Give ongoing support. Set up next meeting in 1-2 mos. Invite additional family to attend.

JAMA Intern Med. 2014;174(12)1994

Disclose the Diagnosis

Terminology

Should we say "Mild Cognitive Impairment" or "Early Alzheimer's"?

- Many people have never heard of "Mild Cognitive Impairment."
- Don't falsely reassure ("Phew, thank goodness it's not Alzheimers!")
- But also don't scare people too much. If it's MCI: there's a 30% chance that over the next 6-8 years it may not progress.
- Say: "I'm worried you might have a high chance of **early Alzheimer's.** Let's watch things closely."
- <u>And:</u> "Let's look at changes to make for brain health. There are ways we can help. If this does get worse, it happens very slowly."

Talking Prognosis of MCI

- “There’s a 30% chance that 6-8 years from now you could be exactly the same as you are now.”
- “But there is also the chance that this is the first sign of Alzheimer’s Disease.”
- “Either way, I’ll be here with you. We’re hoping for best. But I’m here to help if things get worse. It’s so good we have your family here with us to help.”

Clin Geriatr Med. 2018 Nov;34(4):563-589

Phrases to use for the newly diagnosed

“**Living with memory loss is not easy, but I will help you live well. We’ll focus on brain health.** We will find ways to help you feel better, think more clearly, and find ways to still enjoy life.”

“**You will not have to walk this path alone.** Your family, your friends, and me are with you as you move forward.”

Living With Memory Loss. 2017. https://healthonline.washington.edu/

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Who Needs a Referral to Neuro?

- It should be a shared decision with patients.
- It’s OK to hold off on a referral if no red flags. (atypical neurologic symptoms or age < 65)
- For some cases: it’s OK to work up and follow, build trust with patient and family.
- But be aware of visual hallucinations…

Visual Hallucinations

- Raises question of Lewy Body Disease (LBD)
- LBD often a complex determination.
- Has major treatment implications (if LBD, much higher risk from antipsychotics.)
- Patients with visual hallucinations should be referred to a Neurologist.

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Brain Health Checklist

- ☐ **Alcohol (and drugs)**: Limiting 0-1 drinks will help.
- ☐ **Medications**: sedating and anticholinergic
- ☐ **Contributing Conditions**: Sleep apnea, hearing loss.
- ☐ **Exercise**: Daily brisk walks with a friend.
- ☐ **Cognitive Stimulation** Socialization (generally more useful than puzzles.)
- ☐ **Nutrition** Mediterranean/ MIND diet good to recommend.

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Referrals for Support

- Reinforce that life continues for potentially many good years down the road. With the right support it’s possible to live well with memory loss.
- And your local Area Agency on Aging is your friend.
- Your local chapter can help people get the referrals to the programs and support they need to make life better.

https://www.dshs.wa.gov/ALTSA/resources

Powerful Tools for Caregivers

Free 6-week classes.
"Take care of yourself while
you take care of a loved one."

www.powerfultoolsforcaregivers.org

Alzheimer's Association Help Line

- 24/7 National Helpline 800.272.3900
- Staffed by Social Workers (translators available.)
- Urgent advice. Makes referrals to local chapters.
- Free service available to all.

alzheimer's association®

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DPOA-HC (Proxies)

- Decisions by the proxy, at the point of care, are what is most important.
- Early in MCI: So important for patients to designate, in a legal form who their proxies would be: With *alternates.*
- Key point: over 20 years, their spouse may no longer be able to serve.

Takeaways

- Even if diagnosis is mild cognitive impairment, mention high concern for Alzheimer’s disease.
- But include optimism. “With support, people can live well with dementia.” Explain that some prognostic uncertainty is unavoidable.
- If visual hallucinations => important to refer to a Neurologist, given possibility of Lewy Body Disease.
- Provide support resources.
- Identify DPOA *with alternates* while they’re still able.

Q+A

Download Free Summary Tools!

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Cognition-PrimaryCare.org

Cognition in
Primary Care