CLINICAL PROVIDER PRACTICE TOOL

COGNITIVE IMPAIRMENT IDENTIFICATION

Annual Exam
Mini Screen

Tools
Mini-Cog or GPCOG AND
Family Questionniare (if family available)

IF

Normal → **Follow up in 1 year**

Mini-Cog < 4* or GPCOG < 9
Family Questionnaire > 2

For diverse populations see ACT website:
www.actonalz.org/screening-diverse-populations

Cognitive Assessment
(same day or new visit)
+ include family

Tools
One of the following: SLUMS, MoCA, Kokmen STMS, MMSE-2 or MMSE
AND Family Questionnaire

IF

Normal → **Follow up in 1 year**

Score falls outside of normal range

Normal Range:
SLUMS = 27–30 (HS education)
MoCA = 26–30 (HS education)
Kokmen STMS = 29-38
MMSE/MMSE-2 = 27–30

Family Questionnaire < 3

Option 1
Do complete dementia workup
(see provider checklist)

Option 2
Refer to: Champion in your practice, neurologist, neuropsychologist**

*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.

**Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Testing is typically maximally beneficial in the following score ranges:

SLUMS = 18–27
MoCA = 19–27
Kokmen STMS = 19–33
MMSE/MMSE-2 = 18–28

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)
- Review onset, course, and nature of memory and cognitive deficits (Alzheimer's Association Family Questionnaire may assist) and any associated behavioral, medical 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, MMSE)
- Assess mental health (consider depression, anxiety, chemical dependency)
- 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

Diagnostics

Lab Tests

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

Neuroimaging

- CT or MRI 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 maximally beneficial in the following score ranges: MoCA 19-27; SLUMS 18-27; MMSE 18-28; Kokmen STMS 19-33

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 members, friends, or other care partners**
- Review intervention checklist for Alzheimer's disease and related dementias
- Refer to Alzheimer's Association Minnesota-North Dakota 24/7 Helpline at 1-800-272-3900 and/or the Senior LinkAge Line® at 1-800-333-2433

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
- Contact the Alzheimer's Association Minnesota-North Dakota 24/7 Helpline at 1-800-272-3900 or the Senior LinkAge Line® at 1-800-333-2433
- Resources for diverse populations: www.actonalz.org/screening-diverse-populations
- Provide After a Diagnosis[1]
- Provide Taking Action Workbook[7]

Stimulation / Activity / Maximizing Function

Daily Mental, Physical and Social Activity
- Provide Living Well Workbook[5] (includes nonpharm therapies for early to mid stage)
- Adult day services (mid to late stage)
- Sensory aids (hearing aids, pocket talker, glasses, etc.)

Safety

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

Driving
- Counsel on risks
- Refer for driving evaluation[2]
- Provide At the Crossroads[3]

Medication Management
- Family oversight or health care professional

Financial / Legal
- Encourage patient to assign durable power of attorney; elder law attorney as needed

Advance Care Planning

Complete Advance Care Plan
- Refer to advance care planning facilitator within system, if available
- Encourage completion of healthcare directive forms[4,6]

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)

Tools

Mini-Cog
- Public domain: www.mini-cog.com
- Sensitivity for dementia: 76-99%
- Specificity: 89-93%

Montreal Cognitive Assessment (MoCA)
- Public domain: www.mocatest.org/
- Sensitivity: 90% for MCI, 100% for dementia
- Specificity: 87%

St. Louis University Mental Status (SLUMS)
- Public domain: http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf
- Sensitivity: 92% for MCI, 100% for dementia
- Specificity: 81%

Measure/Assess IADLs
- http://consultgeri.org/try-this/dementia/issue-d13.pdf

Family Questionnaire
- www.actonalz.org/pdf/Family-Questionnaire.pdf

Mini-Mental Status Exam (MMSE)
- Copyrighted: www4.parinc.com/Products/Product.aspx?ProductID=MMSE
- Sensitivity: 18% for MCI, 78% for dementia
- Specificity: 100%

Note: The MMSE is not a preferred tool in memory loss assessment. Accumulating evidence shows it is significantly less sensitive than both the MoCA and SLUMS in identifying MCI and early dementia.

Dementia Management Resources

1. **After a Diagnosis**
   www.actonalz.org/provider-practice-tools
2. **American Occupational Therapy Association**
   myaota.aota.org/driver_search/index.aspx
3. **At the Crossroads: Family Conversations About Alzheimer's Disease, Dementia & Driving**
   www.thehartford.com/alzheimers
4. **Honoring Choices Minnesota**
   www.honoringchoices.org
5. **Living Well Workbook**
   www.actonalz.org/pdf/Living-Well.pdf
6. **Health Care Directive**
   www.extension.umn.edu/family/live-healthy-live-well/healthy-futures/health-care-directive/
7. **Taking Action Workbook**
   www.actonalz.org/pdf/Taking-Action.pdf

References: Provider Checklist

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