Physician Guidelines for the Screening, Evaluation, and Management of Alzheimer’s Disease and Related Dementias

Created By
THE ALZHEIMER’S PROJECT
CLINICAL ROUNDTABLE
December 2018
Second Edition
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The Alzheimer's Project is a regional initiative established by the San Diego County Board of Supervisors to address the toll of Alzheimer's and related dementias on families, communities and our healthcare systems. The Clinical Roundtable is one of four groups to address these issues. The Clinical Roundtable brought together neurologists, geriatricians, geriatric psychiatrists, and geriatric psychologists in 2015 to begin to assess current clinical practices, and develop best practices standards for primary care physicians, internists, psychiatrists, nurse practitioners, and physician assistants caring for older adults in their practices.

Focus of the Clinical Roundtable

- Development of standards for screening, evaluation and diagnosis of Alzheimer’s disease and related dementias.
- Development of guidelines for the management of the behavioral and psychological symptoms and issues experienced by those afflicted.
- Education of primary care practitioners and their staff on standards and guidelines leading to countywide achievement of best practices.
- Identification of resources for physicians and their staff, as well as family caregivers.
- Dissemination of tools for effective communication with patients and their caregivers

These tools have been created to assist primary care physicians for managing patients with memory loss and dementia, as well as family members and caregivers affected by this disease. Primary care physicians practicing internal and family medicine significantly outnumber specialists including neurologists, geriatricians and psychiatrists combined. Therefore, as the incidence and prevalence for memory disorders continue to rise to unprecedented, monumental levels, it is inevitable that screening, evaluation, diagnosis, and treatment of many patients with Alzheimer’s disease will be managed by primary care physicians. The Clinical Roundtable encourages the use of these tools to facilitate a more uniform approach among San Diego healthcare providers. The goal is to establish clinical standards of practice to improve patient care and outcomes.

The majority of patients living with dementia can be effectively managed by primary care providers. These tools and additional training are offered to increase the capacity of primary care providers in that regard.

However, when the clinical presentation suggests a condition other than uncomplicated Alzheimer's disease or if the presentation of a particular patient is concerning to the practitioner, referral to a specialist is recommended. These guidelines are intended to be a living document that will change as advances are made in the field. It is planned that the Clinical Roundtable will convene for periodic review of research literature and assessment of practice in the community to update these guidelines. Further, practitioners will be asked for their feedback on the algorithms, specific screening and evaluation instruments, and their impression of the impact on their increased capacity due to use the guidelines. This is the second edition (December 2018) of the Guidelines.
Background

Cognitive impairment and dementia are under-diagnosed in older individuals. This can lead to safety and health consequences, and also delays adequate evaluation and potential treatment. In addition to supporting a diagnosis of cognitive impairment, screening and evaluation of cognition may identify reversible conditions contributing to cognitive changes, or may help to reassure someone with cognitive concerns whose cognition in fact is normal.

The terms dementia, MCI, Major Neurocognitive Impairment and Mild Neurocognitive Impairment are used here with some interchangeability. The current DSM-V terminology is not uniformly used.

Dementia is an acquired decline in memory and/or other areas of cognition or behavior of sufficient magnitude to cause impairment of social or occupational functioning. DSM V has developed the term Major Neurocognitive Decline (MNCD), used with a variety of billing codes to describe dementia and related conditions. Major Neurocognitive Disorder (Dementia) as defined by the DSM-V includes:

- Cognitive deficits in one or more areas of cognition, such as memory, language, visuospatial abilities (apraxia, aphasia, agnosia), or executive function,
- Cognitive deficits must impair social or occupational functioning,
- Gradual onset and progressive cognitive decline,
- Not due to other CNS cause of dementia, substance abuse, or systemic conditions that can cause dementia,
- Not due to delirium,
- Not accounted for by another Axis 1 disorder.

Mild Cognitive Impairment (MCI), or Mild Neurocognitive Disorder, is marked by focal or multifocal cognitive impairment with minimal impairment of instrumental activities of daily living (ADL) that does not cross the threshold for a dementia diagnosis. MCI can be the first cognitive expression of Alzheimer disease (AD), or may be secondary to other disease processes (i.e., other neurologic, neurodegenerative, systemic, or psychiatric disorders) that can cause cognitive deficits. Caveat: brief screening tests such as the MiniCog are less sensitive for detection of MCI than for dementia.

Starting the Conversation

When to Begin Discussion of Cognition in an Older Adult:
- Annual Wellness Visit,
- Warning Signs expressed by patient and/or family member,
- Patient who forgets appointments or is noncompliant with medications,
- Upon observation by a healthcare professional during a scheduled office visit.

Annual Wellness Visit

Medicare beneficiaries are eligible for an Annual Wellness Visit (AWV), which is separate from the Initial Preventive Physical Examination or other routine physical checkups. The CMS-prescribed components of an AWV includes a review of the beneficiary’s potential risk factor for depression, using an appropriate screen such as the PHQ-2 or PHQ-9, as well as a check for cognitive impairment, as follows:

“Detect any cognitive impairment the beneficiary may have: Assess the beneficiary's cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others.”

The Annual Wellness Visit includes a Health Risk Assessment (HRA), and physician discretion will guide the implementation and use of the HRA questionnaire. Each insurance payer may specify their own HRA questionnaire. While Medicare does not identify or prescribe a particular cognitive screening test, many practitioners use the Mini-Cog test.

Having the Conversation

Recommended initial questions to ask older patients regarding their concerns about their memory or cognition are:

- Are you worried about your memory?
- Have you noticed a change in your memory that concerns you?
- During the past few months, have you had any increasing problems with your memory?

It is important to focus on change in function or abilities over the past six months to two years. When the practitioner detects any cognitive impairment in either an AWV, a routine physical checkup, or other appointment, s/he may find it an appropriate opportunity to either begin a discussion, or suggest a follow-up appointment to discuss concerns of the patient, family member or physician.

The Gerontological Society of America’s KAER Toolkit suggests, “By raising this topic, PCPs will communicate to their older adult patients that brain health and changes in memory and cognition that may occur in aging are important aspects of their overall health. Raising the topic will also help to normalize attention to cognition in primary care and encourage older adults to be aware of changes in their cognition and to tell their PCP about cognition-related concerns, if any. Many older adults are reluctant to express such concerns to their PCP, in part because of fear and stigma often associated with dementia. A frank yet sensitive introduction to the topic by the PCP is a highly appropriate first step to kickstart the cognition conversation. This approach can open the way for older adults to reveal any cognition-related concerns they may have.”

The K in KAER stands for Kick Starting the conversation about cognitive impairment. This may include questions about cognition-related function, such as difficulty paying bills or directions to a familiar place. Practitioners can refer to the 10 Warning Signs to direct the conversation. Tools, including short videos on suggested interactions, are available on the website https://championsforhealth.org/alzheimers. Listening and acknowledging concerns of a patient’s family member or caregiver is usually most informative as the individuals with cognitive decline often do not recognize their deficits. The use of an informant survey such as the AD8 or IQCODE is very helpful as part of the follow-up appointment. Family members can be handed the survey at check-out, and asked to complete it prior to the next, more comprehensive visit. By completing the survey outside of the medical office the family member has more time to recall specific concerns, and can provide this valuable information to the provider without disclosing too much in front of their loved one.

Some key messages to impart to older adults include:

- The brain ages, just like other parts of the body.
- Cognitive aging is not a disease, and is not the same as Alzheimer's disease or other dementia. It is a natural, lifelong process that occurs for everyone, and is different for each person.
- Some cognitive functions improve with age.
- There are steps individuals can do that may promote and support their cognitive health.

Individuals concerned about their memory may be among the “Worried Well” and need reassurance that their experience is part of normal aging. Tracking concerns over time will give the practitioner information regarding changes in cognitive function.
### Screening for Dementia

**Recommended Screening Algorithm for Adult Cognitive Impairment**

<table>
<thead>
<tr>
<th>SCREENING VISIT</th>
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<tbody>
<tr>
<td>Generally due to concerns about cognition or function, noted by Patient, Family Member or Physician</td>
</tr>
</tbody>
</table>

| History |
| Changes in cognition and/or function |
| Ask about 10 Warning Signs |

| Conduct Cognitive Screen |
| Assess for Red Flags |
| Mini-Cog ≤3 |

| Optimal |
| Conduct Informant Screen |
| AD8 ≥2 |

| IF FAIL COGNITIVE SCREEN OR RED FLAGS |
| Red Flag Conditions |
| Rapid Progression (within 6 mos) |
| Recent Sudden Changes |
| Young Onset (<65) |

<table>
<thead>
<tr>
<th>10 WARNING SIGNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Memory loss disrupts daily life</td>
</tr>
<tr>
<td>2 Challenges in planning or problem solving</td>
</tr>
<tr>
<td>3 Difficulty completing familiar tasks</td>
</tr>
<tr>
<td>4 Confusion with time or place</td>
</tr>
<tr>
<td>5 Trouble understanding visual images or spatial relationships</td>
</tr>
<tr>
<td>6 Problems with words</td>
</tr>
<tr>
<td>7 Misplacing items and inability to retrace steps</td>
</tr>
<tr>
<td>8 Decreased or poor judgment</td>
</tr>
<tr>
<td>9 Withdrawal from work or social activities</td>
</tr>
<tr>
<td>10 Changes in mood and personality</td>
</tr>
</tbody>
</table>

| IF PASS |
| Reassure Patient & Family |
| Note: Passing cognitive screen does not preclude a mild, early or subclinical problem. Consider rescreening in 12 months, or sooner if changes become more noticeable. |

<table>
<thead>
<tr>
<th>ASSESS REVERSIBLE FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Hearing</td>
</tr>
<tr>
<td>Delirium</td>
</tr>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>Uncontrolled illness or infection</td>
</tr>
</tbody>
</table>

| CONDUCT OR REVIEW RECENT LAB TESTS |
| CBC, Comprehensive Metabolic Panel, TSH, B12 |

| NO Reversible Factors |
| PROCEED TO EVALUATION |

<table>
<thead>
<tr>
<th>TREAT REVERSIBLE FACTORS</th>
</tr>
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<tbody>
<tr>
<td>NO Improvement After Treating Reversible Factors</td>
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</table>

| CONSIDER REFERRAL TO PSYCH IF SEVERE DEPRESSION |

**An algorithm for screening**

An algorithm for screening was created by clinicians with expertise in Neurology, Geriatric Medicine, Geriatric Psychiatry, Psychiatry and Geriatric Psychology representing different San Diego health care systems. The members reviewed guidelines and studies of different screening tests and questionnaires, as well as screening algorithms proposed by organizations across the country, including major universities and the Alzheimer’s Association.

The goal was to develop an algorithm of when screening should be considered, and what brief instruments have reasonable evidence for use. Additional goals were to define a brief workup and focused management that should follow a positive screen, and to determine whether there are potentially treatable factors that should be addressed before undertaking or referring the patient for a more detailed evaluation.

**Intended use**

Primary care physicians, internists, psychiatrists, nurse practitioners, and physician assistants caring for older adults in their practices, as well as psychiatrists and geriatric psychiatrists can use the algorithm to carry out a focused screening. This algorithm was developed for use with older patients where cognitive decline is suspected or has been observed. This type of screening could potentially be used in other settings, for example in an Emergency Room or preoperatively to rule out other conditions presenting as disorientation or dementia. Other medical assistants (MA, CNA) in the practice can assist the screening by conducting portions of the algorithm, including the MiniCog and collecting informant information while rooming the patient.

**Efficacy**

The screening instruments selected are the MiniCog, a brief direct test of cognition; and the AD8, a questionnaire for an informant. These may be used separately or together. Studies suggest that a combination of direct cognitive testing and informant assessment is more accurate in detecting cognitive decline than either one alone.

Studies of the MiniCog suggest that it has sensitivity of over 80% and specificity ranging from 60 – 80% to detect dementia. Studies of the AD8 suggest that it has sensitivity and specificity that both exceed 80% to detect dementia. These results compare favorably with other widely used tests such as the Mini-Mental State Examination (MMSE).

Mild cognitive impairment (MCI) or mild neurocognitive disorder (MNCD) refers to a lesser degree of cognitive decline than dementia. These conditions may be caused by many different factors. Brief screening tests or questionnaires are less sensitive for MCI or MNCD than for dementia.

**How to utilize the tool**

An algorithm for cognitive screening indicates the types of symptoms that may trigger a screen, and the process of using the MiniCog and/or AD8. The MiniCog and AD8 instruments and scoring keys are included in this document, and are available online.

Scoring cut-offs for these instruments are listed. If a screen in positive, medical factors, depressive symptoms and a brief panel of laboratory tests should be considered, to determine if there may be treatable factors. Hearing and vision should also be considered as factors to address.

If a screen is negative, there is a decreased chance that dementia is present but does not rule out MCI. The clinician may decide to pursue a more detailed evaluation anyway, for example if there are issues such as decisions about driving, work or finances. If the screen is negative, the clinician may decide to rescreen the patient during follow-up at six months or one year.

Several RED FLAG symptoms or features are listed, as examples of situations where a more detailed evaluation should be considered, regardless of the results of the screening. A positive screen, with or without an attempt to determine and correct reversible factors, should lead to an evaluation.
Recommended Screening Instruments

**Mini-Cog**
http://www.alz.org/documents_custom/minicog.pdf
Normal range: ≥ 4

**Informant/Family Questionnaire**
Normal Range: 0 - 1

**Patient Health Questionnaire for Depression (PHQ-9)**
PHQ-2 are the first two questions of the PHQ-9 (see page 51)

**Optional: Geriatric Depression Scale**
http://geriatrictoolkit.missouri.edu/cog/GDS_SHORT_FORM.PDF
Reproducible copies are included in the back of this booklet.

Mild Cognitive Impairment

Mild Cognitive Impairment (MCI) is marked by focal or multifocal cognitive impairment with minimal impairment of instrumental activities of daily living (IADL) that does not cross the threshold for a dementia diagnosis. MCI can be the first cognitive expression of Alzheimer disease (AD), or may be secondary to other disease processes (i.e., other neurologic, neurodegenerative, systemic, or psychiatric disorders) that can cause cognitive deficits. While MCI can lead to major neurocognitive disorders in the future, it can also stay stable in its presentation, or it can improve.

Mild Neurocognitive Disorder is a term developed by DSM-V that overlaps with the description of MCI. The following information is excerpted from a consensus statement by the American Academy of Neurology regarding MCI:

“Amnestic MCI (aMCI) is a syndrome in which memory dysfunction predominates; Nonamnestic MCI refers to impairment primarily in other cognitive domains (e.g., language, visuospatial, executive). The ‘narrow’ definition also includes nonamnestic MCI. The general prevalence rate for narrow criteria varied from 3.2% to 25% of individuals 65 years of age and older across studies conducted. The prevalence rate for the broader criteria varied between 13.4% and 42.9.”

**Age breakdown estimates of prevalence rates are:**
- Ages 60 to 64 years, 6.7%
  (95% CI 3.4%–12.7%, I2 11.0)
- Ages 65 to 69 years, 8.4%
  (95% CI 5.2%–13.4%, I2 10)
- Ages 70 to 74 years, 10.1%
  (95% CI 7.5%–13.5%, I2 25.2)
- Ages 75 to 79 years, 14.8%
  (95% CI 10.1%–21.1%, I2 60.7)
- Ages 80 to 84 years, 25.2%
  (95% CI 16.5%–36.5%, I2 10)

Persons with MCI are at higher risk of progressing to dementia than age-matched controls (high confidence, multiple concordant Class I studies, meta-analysis). But it is important to acknowledge that MCI does not necessarily lead to Alzheimer’s disease or related dementia. In individuals with MCI older than age 65 years followed for 2 years, the cumulative incidence for the development of dementia is 14.9%. Persons diagnosed with MCI may remain stable, return to neurologically intact, or progress to dementia (multiple Class I studies, 14.4%–55.6% reverting to normal).

Assessing MCI

Clinicians should assess for MCI and not assume that reported cognitive concerns are related to normal aging. Clinicians should not rely on historical report of subjective memory concerns alone, and should use validated assessment tools as recommended in the...
screening section, including identification of reversible conditions or factors. For patients who test positive for MCI, clinicians can perform a more formal clinical assessment, and assess for the presence of functional impairment related to cognition before giving a diagnosis of dementia. Serial assessments over time help monitor for changes in cognitive status.

Whenever it is possible to safely do so, patients should be weaned from medications that can contribute to cognitive impairment. They may be counseled that there are currently no pharmacologic or dietary agents shown through scientific research to provide symptomatic cognitive benefits. Regular exercise, minimum of twice per week, has shown benefit in MCI and is recommended as part of an overall approach to management. Individuals with MCI are encouraged to practice the same behaviors as individuals without MCI: eat a healthy diet, stop smoking, use alcohol in moderation, remain physically active, and maintain social connections.

Interested patients may be directed to clinical research to provide symptomatic cognitive benefits. Regular exercise, minimum of twice per week, has shown benefit in MCI and is recommended as part of an overall approach to management. Individuals with MCI are encouraged to practice the same behaviors as individuals without MCI: eat a healthy diet, stop smoking, use alcohol in moderation, remain physically active, and maintain social connections.

Pharmacologic treatments for patients diagnosed with MCI
A number of studies have concluded that the use of cholinesterase inhibitors, memantine, vitamins, and other supplements have proven not to be effective for individuals with MCI. Further, the use of cholinesterase inhibitors and memantine are not FDA approved for MCI, and would be off-label prescriptions. There are a number of studies to support this finding on the American Academy of Neurology (https://aan.com).

Nonpharmacologic treatments effective for patients diagnosed with MCI
Studies have shown that for patients with MCI, treatment with exercise training for 6 months is likely to improve cognitive measures (moderate confidence in the evidence based on 2 Class II studies). Individuals with MCI are encouraged to practice the same behaviors as individuals without MCI: eat a healthy diet, stop smoking, use alcohol in moderation, remain physically active, challenge their brain on a regular basis and maintain, and possibly expand, social connections.

Background
Alzheimer’s disease (AD) is the most common cause of dementia in older individuals. Other common causes are vascular cognitive impairment, Dementia with Lewy Bodies (DLB) and Fronto-Temporal Lobar Degeneration (FTLD). Many other conditions may cause or contribute to dementia, including medically treatable conditions.

Evaluation is more detailed and time-consuming than screening. The clinician performing an evaluation should have a thorough knowledge of diagnoses of cognitive disorders such as Alzheimer’s disease and other types of dementia, and should also be comfortable disclosing a diagnosis of Alzheimer’s disease or other dementia to patient and family.

There are many guidelines for the evaluation of dementia. Recent guidelines for Alzheimer’s disease, Mild Cognitive Impairment (MCI) due to AD, as well as prodromal AD emphasize biomarkers for amyloid and neurodegeneration in addition to clinical evaluation. Because these biomarkers are not yet available for routine clinical use, we have emphasized clinical evaluation.

Diagnostic criteria also exist for vascular dementia, DLB, FTLD, and other disorders.

An accurate diagnosis of cognitive impairment, dementia and its etiology can help to guide the patient and family regarding planning, accessing family and community resources, and appropriate use of symptomatic treatment.

An algorithm for diagnostic evaluation
An algorithm for diagnostic evaluation was created by a group of clinicians with expertise in Neurology, Geriatric Medicine and Psychiatry, representing different San Diego health care systems. The members reviewed guidelines and studies of evaluation, as well as published diagnostic criteria. The goal was to develop an outline of the elements of evaluation of dementia or cognitive loss, to help to guide clinicians and improve the quality of care.

Who should carry out an evaluation?
Physicians, Physician Assistants, Nurse Practitioners, or a clinical team member with adequate training can use the algorithm to carry out an evaluation. The clinician or team member should have a strong knowledge base concerning cognition, aging and different types of dementia, and also experience in how to disclose the diagnosis, develop a management plan, and make appropriate use of community resources.

For patients with unusual or uncommon disorders, referral to a subspecialty dementia clinic is advisable. Unusual clinical pictures, including progressive aphasia, progressive visuospatial impairment, apraxia; early movement disorder features, young onset of cognitive impairment (before age 65) and rapidly progressive dementia are often best evaluated in a subspecialty dementia clinic. The presence of a strong family history of dementia may often require assessment by a subspecialty clinic.

The evaluation process
An evaluation typically will consist of at least one detailed visit to obtain the necessary elements of history, examination, cognitive assessment, and to determine appropriate laboratory testing, neuroimaging and other consultation or tests as appropriate.

1) Obtaining collateral history from an informant to document cognitive, functional and behavioral symptoms is strongly recommended whenever possible.

2) Discussion of the results of the evaluation, disclosure of the likely diagnosis, the prognosis, and an outline.

3) Referrals and additional testing as a result of the evaluation require clinical judgment.
Alzheimer's Clinical Roundtable
Recommended Evaluation Algorithm

**Patient Referred for Evaluation of Adult Cognitive Impairment**

**Based on Results of Screening Protocol**

Evaluation to be conducted by PCP/Neurologist/Psychiatrist as appropriate

### Diagnostic Workup

- **Detailed History:** Informant Interview (QDRS, IQCODE, AD8), Cognition, Function, and/or Behavior Changes
- **Neurological exam**
- **Mental Status Test:** MOCA or SLUMS
- **Depression Screening:** Geriatric Depression Scale 7 Item (≥8)
  - PHQ-9 and/or Structured Questions

#### If MOCA or SLUMS Normal

- Reassure patient.
- Consider rescreening 3-6 months
- If concern re MCI consider Neuro-psychological testing

#### If Persistent Depression

- Refer to psychiatrist, other specialists or treat as appropriate

### Diagnosis

**Typical Dementia Syndrome**

- Probable Alzheimer's Disease w/ or w/oout cerebral vascular co-morbidity
  1. Discuss & disclose; counsel patient and family
  2. Develop Treatment/Management Plan
  3. Access/provide community resources

**Atypical Cases**

- Parkinsonian features, hallucinations, prominent aphasia, early onset, rapid progression, fluctuations, unexplained visual impairment, severe depression
  - Referral to neurologist, psychiatrist, or geriatrician recommended

**If MOCA ≤ 25 or SLUMS ≤ 26**

- Proceed to Labs & Imaging
  1. Labs: Comprehensive metabolic panel if not already done at screening, or others as appropriate
  2. Imaging study: CT or MRI
  3. Neuropsychological testing (optional - consider for atypical or mild or early onset cases)

### When to evaluate

The decision to evaluate could follow a screening assessment. In some situations, for example concerns about mild cognitive impairment, or cognitive problems that could affect work, driving or finances, an evaluation is appropriate.

### Efficacy

Clinical guidelines and criteria for Alzheimer's disease (AD) have high sensitivity, in excess of 80-90%, but lower specificity — i.e., they sometimes misdiagnose AD when other etiologies are present.

Biomarkers such as amyloid testing in CSF or amyloid imaging have high specificity, i.e., if they are negative, AD is highly unlikely.

Clinical criteria for other disorders have been less thoroughly evaluated, and were mainly assessed in tertiary referral settings. Sensitivity greater than 80% has been noted for FTD and 70-80% for DLB. Vascular cognitive impairment (VCI) often accompanies AD, and many people with late life dementia show mixed pathology. Vascular risk factors and CT or MRI imaging help to evaluate the likelihood of VCI.

### Additional Testing

- Psychiatric assessment,
- Neuropsychological testing,
- Additional medical evaluation,
- Genetic counseling,
- Neuroimaging testing, e.g., Fluorodeoxyglucose (FDG) PET scan, Amyloid PET scan, Cerebral Spinal Fluid (CSF) testing for AD, laboratory testing for rapidly progressive dementia.

### When to evaluate

The decision to evaluate could follow a screening assessment. In some situations, for example concerns about mild cognitive impairment, or cognitive problems that could affect work, driving or finances, an evaluation is appropriate.

### Efficacy

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### Recommended Evaluation Instruments

Informant surveys may be sent out to caregivers prior to the evaluation appointment. Reproducible copies are included in the back of this booklet.

**Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)**

(available online: http://www.alz.org/documents_custom/shortiqcode_english.pdf)

**Quick Dementia Rating Survey (QDRS)**


**The Montreal Cognitive Assessment (MOCA)**

(Public domain: www.mocatest.org/)

- Normal Range: 26 – 30, for people with < HS education, add 1 point to the total score

The MOCA is a cognitive test that briefly assesses executive/visuospatial function, memory, language, attention, calculation and orientation. Cut-off scores have been developed and it has been tested in the diagnosis of AD, DLB and PD-related disorders. Translated versions are available, in many languages, and there are 3 alternative versions in English.

Although the MOCA may be used as a stand-alone test, and has relatively high sensitivity for the diagnosis of dementia, it is less sensitive for MCI or mild dementia. In that setting, additional testing, either office-based if the clinician has appropriate knowledge or skills, or by a neuropsychologist, is strongly recommended.
Alzheimer’s Disease
Most common type of dementia (60-80% of cases).
Gradual onset and progression of memory loss, disorientation, impaired judgment/problem solving, and language. Behavioral changes may include apathy, depression, and delusions. Social skills are typically preserved.

Dementia with Lewy Body Disease or Parkinson’s Dementia
Second most common type of neurodegenerative dementia (up to 20% of cases).
Hallmark symptoms include visual hallucinations, REM sleep disorder, parkinsonism, and significant fluctuations in cognition.

Fronto-Temporal Dementia
Third most common type of neurodegenerative dementia primarily affecting individuals in their 50s and 60s. Defined by EITHER marked changes in behavior/personality OR language variant (difficulty with speech production or loss of understanding of word meaning). More recently, the term Fronto-temporal Lobar Degeneration has been used to include behavioral variant FTD, Progressive Aphasia, and movement disorders with a prominent cognitive component, namely Corticobasal Syndrome (CBS) and Progressive Supranuclear Palsy (PSP)

Vascular Dementia
Although relatively rare in pure form (10% of cases), vascular changes often coexist with Alzheimer’s disease, and mixed dementia (Alzheimer’s plus vascular) or multiple etiology dementia is often found in elderly individuals. Symptoms often overlap with those of AD; history or physical exam findings may suggest stroke(s).

Disclosing a Diagnosis
Once an evaluation is completed, the practitioner should be prepared to speak with the patient and caregiver or family members as a unit. Often, the disclosure of a diagnosis is the maximum amount of information the patient can handle at the first post-diagnosis appointment, and the provider may want to schedule a longer, follow-up appointment to fully orient the patient and caregivers of important first steps.

Physicians may be reluctant to disclose a specific diagnosis of dementia and to mention Alzheimer’s disease as such a diagnosis may change the physician-patient relationship. Disclosure has been widely studied, and provided that it is done sensitively and with knowledge of the social and family dynamics, it is generally a helpful part of the process. Many families are relieved at obtaining closure regarding a diagnosis and explanation for the problems that they have noted. Disclosure should also include the review, assessment and discussion of medical, personal and social factors that may be impacted by dementia.

Initial discussion and disclosure may cover:

- The primary diagnosis.
- Contributing factors to the diagnosis (e.g., medical, neurological or psychiatric factors). Examples include depression, vascular risk factors, sleep disorders, medical comorbidity that may affect the brain, medications that may have cognitive side effects.
- Recommendations regarding questions such as work, driving, managing finances.
- Personal and home safety.

At the time of disclosure, impress upon the caregiver that the patient should not be left alone for the first 72 hours as he/she processes the information. Inform the caregiver how to reach you during this critical period. Acknowledge that the discussion carries with it significant impact as the patient and caregivers attempt to normalize their reaction and link response to expected needs. You may want to explain the stages of the grief process upon receiving a diagnosis of dementia: Denial, Anger, Bargaining, Depression, and Acceptance.

The most critical topics to cover as soon as possible include:

- Medication options:
  - Primary and proven treatment options; disclose those that are evidence based and sufficiently studied, and explain these as standards of practice.
  - Less well established; explain the warnings regarding research or lack thereof, the fact that these medications are chemicals whether natural or man-made.
- Driving – physician assessment of the patient’s capacity to continue to drive, and when that should be re-evaluated. Physicians have a legal obligation to report patients with diminished capacity. If uncomfortable making this disclosure, this would be an appropriate referral to a specialist.
- Finances and Legal Issues.
- Community resources for both the individual and caregivers,
- Social resources,
- Housing: home modifications, long-term care options,
- Treatment of cognitive and behavioral symptoms,
- Management of vascular risk factors,
- Lifestyle factors such as diet, exercise, sleep, alcohol, etc.
• Discussion of caregiving and of resources,
• Prognosis,
• Genetic questions (more appropriate for younger onset of dementia),
• Research options, enrollment in clinical trials (see Resources for Clinical Trials).

Five Action Steps Family Caregivers Should Take

1) Establish legal responsibility and create legal documents that will be helpful to you and to your loved one.
2) Understand the diagnostic process, symptoms, and course of memory loss and dementia.
3) Care for yourself; a healthy, rested caregiver is a more effective caregiver.
4) Join a support group.
5) Plan for the future. Do research and know what lies ahead to plan accordingly.

Initial Use of FDA Approved Medications for Cognitive Symptoms of Alzheimer’s

After a diagnosis and disclosure of Alzheimer’s disease, many patients and caregivers may be looking for therapeutic options. Cholinesterase inhibitors have been extensively studied for symptomatic effects on cognition in Alzheimer’s disease. Clinical trials and studies show statistically significant improvement on MOCA scores but small benefits vs. placebo among individuals with mild through severe Alzheimer’s. Overall, they may stabilize cognition or slow its progression but do not slow the progression of the underlying disease. The most common of the cholinesterase inhibitors are: donepezil (Aricept®), rivastigmine (Exelon®) available in patch form, and galantamine ( Razadyne®). These medications can be continued as long as no negative side effects occur. Different doses of cholinesterase inhibitors are available, and usual practice is to start a patient on a low dose, and titrate to a higher dose as tolerated. Memantine (Namenda®) has been shown to have small benefits on cognition and behavior in people with moderate to severe AD, either alone or added to a cholinesterase inhibitor. Memantine did not show benefit in mild AD. Memantine does not slow progress of the underlying disease; however, it is generally well tolerated.

While there are combination pharmaceuticals available, e.g., Namzeric, which combines donepezil and memantine, monotherapy is likely as efficacious as combination therapy with fewer side effects and lower cost. It is possible to combine a cholinesterase inhibitor and memantine in patients with mild AD, but randomized clinical trials have not shown the efficacy of this combination.

There is FDA acceptable evidence that while these medications may alter several measures of dementia, many clinicians remain unsure of their benefits or impact on long term course. In addition to any benefits for function or behavior, prescribing medications can offer hope to the family at a time of great distress. Practitioners should discuss and weigh risks/side effects vs benefits with patients and caregivers, and discontinue use of these medications should side effects persist.

Adverse Effects of Cholinesterase Inhibitors (listed in order of reported frequency):
• Nausea, vomiting
• Diarrhea
• Abdominal pain
• Constipation
• Fecal incontinence
• Dyspepsia
• Weight loss
• Peripheral edema
• Agitation
• Bradycardia
• Hypotension
• Heart failure
• Anemia
• Arthralgias
• Anxiety
• Tremor
• Vertigo
• Wandering
• Gait disturbance
• Falls
• Cough
• Rash
• Pruritis
• Conjunctivitis
• Blurred vision
• Urinary tract infections
• Flu-like syndrome

Adverse effects Memantine (listed in order of reported frequency):
• Fatigue
• Pain
• Hypertension
• Dizziness
• Headache
• Constipation
• Vomiting
• Cough
• Dyspnea
• Confusion
• Somnolence
• Hallucinations
• Anxiety
• Depression
• Aggression

To date, no nutraceutical has been found to have clinical or statistical benefit for dementia. Souvenaid, a medical food, (eicosapentaenoic acid, docosahexaenoic acid, phospholipids, choline, uridine, vitamin E, vitamin C, selenium, vitamin B12, vitamin B6, and folic acid) showed a statistical but not clinical benefit in multicenter clinical trials vs placebo, and its use can be associated with weight loss and diarrhea.

Axona is a powdered form of a ketogenic supplement that also is available as a medical food. It did not show benefits in multicenter clinical trials vs placebo, and its use can be associated with weight loss and diarrhea.

Non-pharmacologic interventions likely have an impact on AD, although this is harder to study and quantify. Similarly to the treatment of many chronic conditions, healthy diet, physical activity, and social interaction have been proven to be the most effective therapies for Alzheimer’s disease and related dementias.
Management of Symptoms of Alzheimer's Disease and Related Dementia

Although cognitive impairment is the clinical hallmark of dementia, behavioral and psychological signs and symptoms of dementia (BPSD), which are also known as non-cognitive neuropsychiatric symptoms (NPS), are extremely common and are responsible for the majority of pain and suffering experienced by the individuals living with dementia and those who love and care for them. In addition, BPSD is a primary factor responsible for the medical and other costs associated with caring for individuals living with dementia. BPSD accounts for at least 30% percent of the cost of caring for community dwelling individuals with dementia.

Research has found that BPSD is associated with:

1) Reduced quality of life for patients living with dementia,
2) Reduced quality of life for family members and caregivers,
3) Early nursing home placement,
4) Hospital admissions,
5) Avoidable morbidity and mortality,
6) Caregiver stress and depression,
7) Reduced caregiver employment income.

The assessment and treatment of BPSD is not simple. BPSD is the result of the interaction of numerous possible factors that are internal and external to the individual living with dementia, including the brain disease responsible for the dementia and the environment in which the individual is living.

Recently, a number of groups and organizations have developed and published excellent algorithms, treatment guidelines and other resources to help clinicians and family members accurately diagnose and treat BPSD. The goal of this section is to succinctly summarize previous developed information with references so that the treating provider can easily obtain additional and more detailed information when necessary, and so that the provider knows when to seek consultation from a specialist in this area. Specifically, this guide contains an assessment and treatment algorithm, a number of guidelines for assessing and treating some of the most common forms of BPSD, and a form for caregivers to use when preparing to meet with a clinician in order to obtain help with BPSD.

**DICE: Describe, Investigate, Create, Evaluate.**

Over the past 15 years a number of publications have included excellent algorithms for the assessment and treatment of BPSD and many are included as references in these guidelines. Though the depth and detail of the recommendations vary across these publications, all contain the same basic steps and concepts as the DICE algorithm, authored by Helen Kales, MD, and her colleagues at the University of Michigan: accurate description of the behaviors, systematic investigation of their cause(s), use of the safest and most precisely targeted interventions possible, and the need for periodic reassessment to determine if the interventions are working and if they are still needed.

The Alzheimer’s Project Clinical Roundtable recommends the use of the DICE algorithm in the assessment and management of behavioral and psychological signs and symptoms of dementia. DICE stands for Describe, Investigate, Create, and Evaluate. The algorithm diagrams created provide the practitioner with a snapshot for consult usage. This document also contains more detailed information on the use of the DICE approach. This perspective mandates that the clinician assume the stance of a scientist or private investigator and begin to systematically collect information that will ultimately lead to an understanding of the causes and associated best remedies of the behavior(s). This is, in essence, the underlying premise of the DICE approach. Although this approach may consume more time and other resources up front, in the long run the benefits in terms of improved quality of life for all involved and decreased healthcare expenditures, will far surpass these costs.

**DESCRIBE**

When an individual living with dementia develops behavioral symptoms, the clinician should guard against jumping to the conclusion that the symptoms are exclusively and intrinsically an expected outcome of the dementia illness. A somewhat liberal and yet compassionate and useful perspective is to view problem behavior or behaviors as a form of communication limited, perhaps, by the cognitive losses that are occurring as part of the dementia. This perspective mandates that the clinician assume the stance of a scientist or private investigator and begin to systematically collect information that will ultimately lead to an understanding of the causes and associated best remedies of the behavior(s). This is, in essence, the underlying premise of the DICE approach. Although this approach may consume more time and other resources up front, in the long run the benefits in terms of improved quality of life for all involved and decreased healthcare expenditures, will far surpass these costs.

**Common Behavioral Problems:**

- Food Refusal
- Restlessness
- Combativeness
- Hypersexuality
- Depression
- ADL refusal
- Medication refusal
- Agitation
- Wandering
- Sleep disturbances
- Disinhibition
- Irritability
- Psychosis
- Social withdrawal
- Anxiety
- Aggression

**Disease stages and symptoms.** In patients living with Alzheimer’s dementia, research has demonstrated that certain symptoms are most likely to occur at certain stages of the illness. Knowing this is very helpful because if a symptom like physical aggression occurs early in the course this strongly suggests that the symptom may be related to medical illness or some other psychiatric illness other than the dementia. Below is a table of symptoms created from data collected and analyzed by Jost BC, et al.

<table>
<thead>
<tr>
<th>Common Behavioral Problems:</th>
<th>Peak of Occurrence (% Patients)</th>
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<tbody>
<tr>
<td>Wandering</td>
<td>90</td>
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<tr>
<td>Sleep disturbances</td>
<td>80</td>
</tr>
<tr>
<td>Disinhibition</td>
<td>60</td>
</tr>
<tr>
<td>Irritability</td>
<td>40</td>
</tr>
<tr>
<td>Psychosis</td>
<td>30</td>
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<tr>
<td>Social withdrawal</td>
<td>20</td>
</tr>
<tr>
<td>Anxiety</td>
<td>10</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>-40</td>
</tr>
<tr>
<td>Socially unacceptable</td>
<td>-30</td>
</tr>
<tr>
<td>Agitation</td>
<td>-20</td>
</tr>
<tr>
<td>Anticipation</td>
<td>-10</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>0</td>
</tr>
</tbody>
</table>

**Source:** Jost BC, et al. / Am Geriatr Soc. 1996;44:1078-1081
INVESTIGATE

Critical to the effective management of behavioral issues or symptoms is the thorough investigation of the underlying causes of these behaviors.

Ten Key Points to Consider:

1) New or rapidly worsening behavioral symptoms in a patient with dementia should be considered a sign of an underlying medical illness until proven otherwise.
2) Assess whether a new or recurrent underlying medical factor may be involved.
3) Problem behaviors are often triggered by anticholinergic meds and suboptimal prescribing.
4) Obtain a careful history focused on any changes in the patient’s medical status and medications.
5) There are differences between the psychotic symptoms typically seen in patients with dementia versus the psychosis seen other conditions.
6) The concept “psychobehavioral metaphor” may help with selecting a class of medication with the highest probability of being helpful.
7) In spite of the recent FDA warnings, in certain situations a risk-to-benefit analysis may still favor the use of antipsychotic medications.
8) There are emerging other possibly helpful strategies: prazosin (Minipres®) and dextromethorphan-quineidine (Nuedexta®).
9) The use of both pharmacological and behavioral strategies leads to the best results.
10) Remember that symptoms evolve over the stages of dementia and may decrease or disappear.

Differential Diagnosis of Behavioral Symptoms in a Patient with Dementia

Types of differential diagnosis include:

Medical: suboptimal prescribing, uncorrected sensory deficits, hypoglycemia, pain
Psychiatric: depression, anxiety, paranoia
Psychological: frustration, boredom, TV violence, loneliness, abandonment anxiety
Other: thirst, hunger, fatigue, noise, movement restriction

These can be caused by:

• Suboptimal communication between individual and caregivers,
• Toxic or inappropriate environment,
• Delirium,
• Exacerbation of pre-existing medical illness,
• Onset of new medical problem,
• Medication toxicity (e.g. polypharmacy or suboptimal prescribing),
• Drug or alcohol intoxication or withdrawal,
• Exacerbation of pre-existing psychiatric illness,
• Onset of a new psychiatric illness.

Medical illnesses are often overlooked in older patients, especially those with psychiatric diagnoses or dementia prominently highlighted in their records!

Common “Delusions” in Patients with Dementia

Delusions are a common behavioral issue among individuals with dementia. The most frequent elusions are:

• Accusations of infidelity,
• Persons or images from TV are real,
• Fear of abandonment,
• Accusations of theft of one’s property,
• Claims of impersonation (spouse is imposter),
• Current residence is not one’s home,
• Misidentification of familiar persons.

How to Recognize Delirium

Begin by having a high index of suspicion and then ask:

• Have there been any recent medication changes?
• Does the patient look physically ill or physically uncomfortable?
• Are the patient’s vital signs reasonable?
• Are the patient’s vital signs around their usual baseline?
• Is the patient’s lab values reasonable?
• Is the patient’s lab values reasonable?
• Has the patient’s mental status changed rather suddenly or dramatically?
• Is the patient suddenly behaving in ways that have never been characteristic for the patient?
• Is the patient ‘s level of alertness and/or attention waxing and waning?

Watch for “Stealth” Anticholinergic Medications:

All sorts of medications can cause delirium but be especially vigilant about those with anticholinergic properties.

Assessment and Treatment of Depression

• Remember that an episode of major depressive disorder in older individuals may not look the same as in younger patients.
• Remember that diagnosing an episode of major depressive disorder through the veil of dementia is difficult and it may be impossible to identify all of the signs and symptoms usually required to make a definite diagnosis. For example, a patient with dementia may have such severe aphasia that they are unable to answer questions about self-esteem or anhedonia.
• Consider using the concept, psychobehavioral metaphor, first described by Pierre Tariot, when attempting to discern the most likely common psychiatric syndrome occurring in a patient who is living with dementia. In essence, the concept invites the clinician to ask him or herself, “if I did not know that this patient had dementia, what common psychiatric syndrome or diagnosis would the signs and symptoms this patient has most resemble?”. A concept closely related to the psychobehavioral metaphor which has been described by Lawlor and Bhattacharyya (2001) has been called “BPSD clusters.” These clusters include: Depression, Apathy, Aggression, Psychomotor Agitation and Psychosis.

Assessment and Treatment of Agitation

All agitation is not the same and, therefore, should not be treated the same. The algorithm provides examples of four types of agitation that have different triggers and, as a result, have different optimal treatments.

Verbal

Aggressive e.g. Threatening, name-calling, profanity
Nonaggressive e.g. Repetitive requests, rocking

Physical

Aggressive e.g. Hitting, biting, scratching, hair pulling, shredding
Nonaggressive e.g. Pacing, sleeping, pounding


In spite of the FDA black box warnings, antipsychotics may still be the best pharmacologic treatment option in patients with BPSD, especially in patients whose behavioral symptoms seem to be triggered by delusions or in patients who have a clear history of a psychiatric disorder that included psychotic symptoms and preceded the onset of dementia illness (e.g. a mood disorder with psychotic features or schizophrenia).
Whenever possible, medication changes should occur one at a time and sufficient time should occur to evaluate the impact of the medication addition prior to another medication change being made.

Factors influencing investigation. There are many factors that may make the investigation of the etiology of BPSD, and its subsequent treatment, difficult. These factors include but are not limited to:

- The **limited** time that many healthcare systems allot for outpatient clinical appointments.
- The **extra time and resources** needed to properly examine a patient with BPSD. For example, severe constipation (obstipation) has been identified as a common trigger of BPSD and yet accurately diagnosing constipation in a patient living with dementia is more challenging for a variety of reasons.
- Often the patient with BPSD is unwilling or unable to cooperate with key components of the evaluation including a digital rectal examination and extra personnel may be needed to assist with the physical examination in order to ensure patient and examiner comfort and safety.
- The **difficulty** that many patients living with dementia have in **providing clear, concise accurate** historical information.
- The **difficulty** that many caregivers, especially family caregivers who are exhausted by the demands of caregiving, have in **providing clear, concise, accurate** historical information.
- The lack of optimal training experiences of many of the clinicians who are on the frontlines in the assessment and treatment of BPSD.
- An insufficient number of well-trained experts who are prepared to diagnose and treat patients with BPSD.

The use of **rating scales** to assess the severity of symptoms, to provide documentation to justify the costs of care and to monitor more objectively the impact of interventions is recommended. The rating scales recommended by Tampi et al. have been included in Appendix 4.

The importance of **searching for medical triggers** cannot be overemphasized. Published research including the work by Woo et al., have found that a significant subset of older individuals, including those who may be living with dementia, are experiencing the problem behaviors due to previously undiagnosed (and therefore untreated medical problems) or due to medical problems that have not been optimally treated.

**CREATE a Care Management Plan**

**Disease Management: General Concepts**

- Define and document target symptoms.
- Identify and optimally treat all medical conditions.
- Identify and remove triggers (e.g. pain, noise, boredom, hunger…).
- Use all possibly helpful tools.
- Depending on acuity of behavior, use behavioral interventions first.
- There is no US FDA-approved treatment for behavioral disturbance associated with dementia.
- Combine behavioral and medication interventions.
- Use the psychobehavioral metaphor (defined in the algorithm chart on page 27 and in the text on page 19) to select initial class of medication.

**Behavioral and Environmental Management of BPSD**

It is advised to develop behavioral intervention strategies with the family members and caregivers prior to utilization of pharmacological management. The algorithms included in this document offer a variety of treatment suggestions to caregivers. Educate and advise them of these essentials:

- **Create a safe, comfortable environment:**
  - Assess the residence for soothing colors, differentiation of surface levels, i.e., rugs, chair seats.
  - Assure adequate lighting, comfortable temperature, furniture with strong arm rests and seats at a comfortable height.
  - Increase or decrease the amount of stimulation.
  - Turn on lights in home, or take the patient outdoors with appropriate solar protection, in late afternoon to avoid sun downing.
  - Provide access to photographs, music to stimulate calming memories.

**Improve suboptimal communication** in order to achieve desired behavioral results. Examples of suboptimal communications include:

- Making more than one request at a time,
- Speaking too fast or with poor diction,
- Not allowing time for the person living with dementia to respond,
- Not using more than one sensory modality,
- Not maintaining eye contact,
- Not assuming a comfortable, relaxed posture,
- Not identifying and verbalizing the patient’s affect,
- Not using simple, direct statements.

Redirect helps to improve communications, and helps the patient refocus in order to be calmer, cooperative, content, and safe. Physicians can refer caregivers to the Redirection Tip Sheet in the back of this book.

**See the Resources for Caregivers for additional resources.**

**Care Refusal**

The caregivers should be coached on dealing with difficult behaviors including the refusal of care when it is occurring. Many factors may be involved in these situations, including anger, stubbornness, uncooperativeness, anxiety, and verbal or physical agitation or aggression. The most common forms of care which are refused are medications, eating, bathing, and clinical appointments. Caregivers should be encouraged to:

- Communicate that the request and refusal is understood,
- Remember who the patient was previous to dementia,
- Avoid arguments,
- Focus on pleasant experiences.

Refer the caregiver to resources to assist with these behaviors. See Resource Sheet.

**Pharmacologic Management of BPSD**

FDA Approved use of cholinesterase inhibitors and memantine may have a role to play in the treatment of BPSD. They may also contribute to the development of BPSD. If a patient presents with BPSD and is currently taking a cognitive enhancer and/ or memantine, efforts should be made to determine if there may be a temporal association between the initiation of treatment and the emergence of BPSD. If a patient with BPSD is not yet taking a cognitive enhancer or memantine, then the addition of a cognitive enhancer or memantine should occur as one of the final steps in symptom management and only after the most pressing behavioral symptoms have been successfully addressed. A cognitive enhancer or memantine should be added sequentially and only after it has been confirmed that the addition of the first medication has not caused problems. See page 24 for more information on these medications.

**Psychotropic Medication Management.** It is important for clinicians involved with the assessment and treatment of BPSD to remember that with only rare exceptions, most types of dementia are
progressive neurocognitive illnesses which means that the underlying disease process leads to ever increasing damage to the afflicted individual’s brain. This reality sometimes leads to worsening behavioral challenges but sometimes leads to improvement in problem behaviors whenever the brain tissue centrally involved in triggering the behavior is damaged and no longer able to play a causal role in the behavior’s occurrence. Once a patient with BPDS has been stable for 3-6 months, if psychotropic medication has been required to manage the behavior, it is then important to initiate a cautious, incremental reduction in psychotropic medication and monitor the patient closely. If the problem behavior(s) does (do) not reappear after several weeks, then another reduction should occur. On the other hand, if at any point a reduction leads to the return of a problem behavior, then the patient should be returned to the dose at which the problem behavior remained in remission.

Pharmacologic Treatment: General Principles
- Use medications better tolerated by older adults (often these are renally excreted),
- Older adults often need lower dosage,
- Check the timing of medication dose against other issues, i.e., diuretics at bedtime should be avoided,
- Start low, go slow and determine lowest effective dose or,
- Start low, increase relatively swiftly and then be prepared for the need to back off in order to determine lowest effective dose,
- Withdraw after an appropriate period and observe for relapse,
- Reduce long-term use of opioid medications,
- Behavioral symptoms vary according to stage of illness and may remit as the illness progresses,
- Refer to the PDR or comparable reference for information on introducing/titrating medication.

Categories of Medications Which May be Helpful:
- Alpha adrenergic blockers
- Antipsychotics
- Antidepressants
- Anxiolytics
- Beta blockers
- Cholinesterase inhibitors
- Dextromethorphan-quinidine
- Hormones
- Memantine
- Mood stabilizers
- Pain medications especially routine acetaminophen

Benzodiazepines
Benzodiazepine is rarely helpful for older patients and should generally be used in a time-limited manner for situational symptoms; it may be helpful for acute agitation. Look for short-acting, renally excreted meds with intermediate half-life and/or rapidly disintegrating formulation. The preferred medications are:
- Lorazepam (Ativan®)
- Oxazepam (Serax®)

Trazodone (Desyrel®) – there is no good data for the use of this medication based on Cochran Reports. Practitioners have found this medication may treat both acute agitation and prevent further episodes, and may be a good choice for insomnia. Dose range is 25–100mg; complete response may take two to four weeks. Sedation is common, and priapism is very rare in older adults.

Prazosin (Minipress®)
The noradrenergic system is the brain “adrenaline” system for attention and arousals. Excessive noradrenergic reactivity produces anxiety and agitation, and contributes to agitation in AD. Prazosin is an alpha-1 receptor antagonist, and crosses the blood/brain barrier. It is non-sedating, does not cause parkinsonism but may reduce BP. It is shown to have long-lasting benefits in PTSD. In AD, dosing is between one and six mg per day.

Dextromethorphan/quinidine
Dextromethorphan hydrobromide and quinidine sulfate (Nuedexta®) is approved for pseudobulbar affect (PBA) in the US and European Union. Dextromethorphan is most well-known as a cough suppressant. Its qualities include:
- a low low-affinity, uncompetitive NMDA receptor antagonist
- α1 (sigma1) receptor agonist
- Serotonin and norepinephrine reuptake inhibitor
- Neuronal nicotinic α3 β4 receptor antagonist
Quinidine is a Class 1 antiarrhythmic. When combined with dextromethorphan, quinidine works by increasing the amount of dextromethorphan in the body.

Dosing in PBA:
- Combination of dextromethorphan (20 mg) & quinidine (10 mg) comes as a capsule to be taken orally with or without food
- Starting dosage: 1x day for 7 days, then every 12 hours
- More than two doses should not be taken in a 24-hour period; medication should be taken around the same times each day
- Drug-Drug interactions: desipramine (levels increase 8-fold), paroxetine (2-fold increase), MAOIs and memantine

Avoiding Suboptimal Prescribing and Polypharmacy
For any indication, use the medicine most appropriate for an older patient and avoid:
- Polypharmacy (too many medications) and the prescribing cascade,
- Prescribing a medication from an essential category of medication that is not senior friendly,
- Prescribing a dose of an essential medication that is larger than needed,
- Prescribing a medication to be taken at a time of day that is not optimal (e.g. diuretics at bedtime),
- Not prescribing a needed medication (e.g. a pain medication),
- Long-term use of opiate pain medication in patients other than those with terminal cancer.

The Beers Criteria List
One of the two most widely used consensus criteria for safe medication use in older adults (the other is the Canadian criteria)
- PIMs = potentially inappropriate medications
- Composed of 53 medications or medication classes divided into 3 categories:
  1) PIMs and classes to avoid in older adults
  2) PIMs and classes to avoid in older adults with certain diseases that the drugs can exacerbate
  3) Medications to be used with caution in older adults (new)
These criteria included designations of the quality and strength of the evidence
- Quality of evidence is designated as high, moderate or low,
- Strength of the recommendation is designated as strong, weak or insufficient,
- Medications are organized according to organ system or therapeutic category or drug,
- The criteria also included rationale and recommendations,
- The 2015 update is not as extensive as the 2012 update, but has 2 additions:
  - o Drugs for which dose adjustment is required based on renal function,
  - o Drug-drug interactions information.
Management of Symptoms of Alzheimer's Disease and Related Dementia

Antipsychotic Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole (Abilify)</td>
<td>4 forms including tablets (2, 5, 10, 15, 20, 30 mg), DiscMelt (10 and 15 mg), liquid and IM</td>
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<tr>
<td>Asenapine (Saphris)</td>
<td>2.5 mg &amp; 5 mg sublingual; q12 hours</td>
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<tr>
<td>Cariprazine (Vraylar)</td>
<td>Capsules (1.5, 3, 4.5 and 6 mg)</td>
</tr>
<tr>
<td>Clozapine (Clozaril)</td>
<td>Refer to psychiatrist</td>
</tr>
<tr>
<td>Iloperidone (Fanapt)</td>
<td>Tablets (1, 2, 4, 6 mg); q 12 hours</td>
</tr>
<tr>
<td>Lurasidone (Latuda)</td>
<td>Tablets (20, 40, 60, 80 mg)</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa)</td>
<td>4 forms including tablets (2.5, 5, 7.5, 10, 15, 20 mg) Zydus (5, 10, 15 20 mg), IM, IM ER</td>
</tr>
<tr>
<td>Paliperidone (Invega)</td>
<td>Tablets (1.5, 3, 6 and 9 mg) Max = 12 mg, Renal = 3 mg</td>
</tr>
<tr>
<td>Pimavanserin (Nuplazid)</td>
<td>Tablet 17 mg (FDA for Parkinson’s disease psychosis</td>
</tr>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>Tabs (25, 50, 100, 200 mg) q 12 hours; Extended release tabs (50, 150, 200, 300, 400 mg)</td>
</tr>
<tr>
<td>Risperidone (Risperdal)</td>
<td>4 forms including tablets and M-Tabs (0.25, 0.5, 1, 2, 3, 4 mg), liquid, Risperdal Consta (q 2 weeks)</td>
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Antidepressant Medications

<table>
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<tr>
<th>Drug</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>10, 20 and 40 mg tabs (20 and 40s are scored). Starting dose is 10 mg. Max dose = 40 mg. Doses above 40 mg not recommended due to QTc prolongation.</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>5, 10 and 20 mg (10 and 20s are scored). Starting dose is 5 mg. Max dose = 20.</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>20, 30, 60 mg tabs. Starting dose 20 mg. Max dose = 60 mg.</td>
</tr>
</tbody>
</table>

Mood Stabilizing Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divalproex</td>
<td>Sprinkles 125; DR 125, 250 500 mg; ER 250 and 500 mg. Oral solution: 250 mg/5 mL. Starting dose = 125 to 250 mg. Dose is determined by clinical response and blood level of total valproic acid (50 to 100 μg/mL). When converting to ER, increase dose by 20%.</td>
</tr>
<tr>
<td>Lithium</td>
<td>Tablets, capsules, oral solution; and ER. 300 mg tabs. ER comes in 300 and 450s. Solution: 8 mEq/5 mL. Recommended trough serum range is 0.4 to 0.8 mEq/L. Starting dose = 300 mg.</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Capsules 150, 300, 400 mg; Tablets 600 and 800; liquid. Starting dose 150 to 300 mg; Max dose = 3600 mg in a divided dose.</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>Caps: 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg, and 300 mg. Oral Solution: 20 mg/mL.</td>
</tr>
</tbody>
</table>

The risks of the interventions provided and the speed of their implementation should be in direct proportion to the pain and dangerousness of the behaviors. Sometimes, the use of less precise medication interventions is needed initially in order to facilitate the investigation for underlying causes. There are a number of practice patterns, regulations and policy issues to consider in the creation of a care plan. Many insurance plans do not yet pay for services that would often help reduce the frequency and intensity of BPSD. For example, adult day healthcare programs that specialize in the care of patients living with dementia are often not affordable for many individuals living with dementia in spite of their proven benefits. These benefits include increasing the quality of life of individuals living with dementia, reducing rates of illness and burn out in family caregivers, reducing the rates of BPSD by providing meaningful and enjoyable activities for patients and the delaying or even prevention of placement in residential care, which is the most expensive method of caring for those living with dementia illnesses. The emphasis on keeping the duration of hospitalizations as brief as possible which may sometimes tempt clinicians to make too many changes in care at the same time, in some instances, makes it difficult to know precisely which intervention was responsible for improvement or, possibly, in worsening of the behaviors. This emphasis may also tempt prescribers to place patients on doses of medication larger than truly needed in order to reduce problem behaviors sufficiently to permit a patient to be discharged to a lower and less expensive level of care. There is a lack of appropriate healthcare facilities that are designed to care for older patients who have concurrent medical and psychiatric problems that needs to be assessed and treated in tandem. For example, most inpatient psychiatric units are not able to care for patients who may require intravenous therapy, and most medical and surgical inpatient units are not designed to handle disruptive behaviors and so often must resort to cautious and judicious use of physical restraint that often becomes itself a trigger for problem behaviors. There is a shortage of specialist trained clinicians. Given the huge mismatch between the projected number of individuals who will be afflicted with dementia and the number of clinicians who have completed specialized training programs to prepare them to efficiently and safely diagnose and treat BPSD,
### Management of Symptoms of Alzheimer’s Disease

#### Caregiver describes behavioral factors:
- Social & physical environment
- Patient perspective
- Degree of distress to patient and caregiver

#### Look for:
- Antecedents
- Patterns
- Context
- Co-occurring events

#### Investigate (Assess)
Investigate possible causes of behavior:
- Medication side effects
- Pain
- Functional limitations
- Medical conditions
- Psychiatric comorbidity
- Severity of cog impairment
- Degree of executive dysfunction
- Poor sleep
- Sensory changes
- Emotional triggers: i.e., fear, abandonment
- Lack of physical activity
- Suboptimal exposure to bright light

Provider, caregivers, clinical team collaborate to create and implement a treatment plan

#### Address physical problems and medical issues first

#### Employ behavioral interventions
- Provide caregiver interventions
- Enhance communication
- Create meaningful activities
- Simplify tasks

#### Ensure that the environment is safe
Increase or decrease the amount of stimulation in the environment

#### If behavioral interventions not effective/partially effective, employ pharmacological management, selecting a class of psychotropic medication based on psychobehavioral "Assume/Assess/Align" model, as below

<table>
<thead>
<tr>
<th>Assume</th>
<th>Assess</th>
<th>Align</th>
</tr>
</thead>
<tbody>
<tr>
<td>patient does not have dementia</td>
<td>psychiatric signs and symptoms</td>
<td>symptoms to best fit psychiatric syndrome eg, major depression, paranoid psychosis,mania etc.</td>
</tr>
</tbody>
</table>

#### Evaluate (And Re-Evaluate)
Evaluate whether "CREATE" interventions implemented by caregiver(s) have been safe/effective
- Make modifications as needed and continue to look for possible underlying causes
- Re-evaluate periodically
- If intervention not effective or if patient or caregiver are in danger, consider referring to neuropsychologist or psychiatrist

---

**DICe APPROACH TO BEHAVIORAL AND PSYCHOLOGICAL SIGNS AND SYMPTOMS OF DEMENTIA**

<table>
<thead>
<tr>
<th>DESCRIBE</th>
<th>INVESTIGATE (ASSESS)</th>
<th>CREATE (TREATMENT)</th>
<th>EVALUATE (AND RE-EVALUATE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver describes behavioral factors:</td>
<td>Investigate possible causes of behavior:</td>
<td>Provider, caregivers, clinical team collaborate to create and implement a treatment plan</td>
<td>Evaluate whether “CREATE” interventions implemented by caregiver(s) have been safe/effective</td>
</tr>
<tr>
<td>- Social &amp; physical environment</td>
<td>- Medication side effects</td>
<td>Address physical problems and medical issues first</td>
<td>- Make modifications as needed and continue to look for possible underlying causes</td>
</tr>
<tr>
<td>- Patient perspective</td>
<td>- Pain</td>
<td>Employ behavioral interventions</td>
<td>- Re-evaluate periodically</td>
</tr>
<tr>
<td>- Degree of distress to patient and caregiver</td>
<td>- Functional limitations</td>
<td>Ensure that the environment is safe</td>
<td>- If intervention not effective or if patient or caregiver are in danger, consider referring to neuropsychologist or psychiatrist</td>
</tr>
<tr>
<td></td>
<td>- Medical conditions</td>
<td>If behavioral interventions not effective/partially effective, employ pharmacological management, selecting a class of psychotropic medication based on psychobehavioral “Assume/Assess/Align” model, as below</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Psychiatric comorbidity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Severity of cog impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Degree of executive dysfunction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Poor sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Sensory changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Emotional triggers: i.e., fear, abandonment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Lack of physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Suboptimal exposure to bright light</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# DICE APPROACH FOR BEHAVIORAL AND PHARMACOLOGIC TREATMENT OF DEPRESSION

## DESCRIBE

Symptoms overlap with behavioral symptoms of dementia. Depressed mood may not be evident in older patients with major depression. Consider the following in older patients: anxiety, insomnia, anorexia, irritability, anger/hostility, insecurity, paranoia, etc.

Presenting symptoms: Depressed mood, tearfulness, anxiety, anhedonia, anorexia, weight loss, insomnia, hyperactivity, irritability, pessimism, suicidal ideation, somatic preoccupation, decreased concentration, psychomotor slowing, social isolation, psychosis.

## INVESTIGATE

- Evaluate underlying medical causes including medication side effects; work-up significant cognitive impairment/dementia.
- Do not assume cognitive impairment is solely due to depression.
- Evaluate for the following: social/family support, past psychiatric and substance abuse history, family mental health history.

## CREATE

**Educate** - patient and family; provide psychosocial interventions to support both patient and caregivers.

**Medication** - Antidepressant medication should be started at low dose and increased slowly. Preferred antidepressant in older adults include sertraline, citalopram, escitalopram.

Psychiatric consultation - consider in context of severe depression, failure to thrive, psychosis, suicidal ideation, history of major psychiatric illness (e.g., bipolar disorder, schizophrenia, past suicidal attempts, severe agitation, etc.).

## EVALUATE

Gather information - from caregivers and patient; use rating scales to track response to treatment.

**Medication response** - Evaluate for side effects of medication within 2 weeks and efficacy within 3-4 weeks.

**Evaluate for consultation** - Worsening symptoms or adverse effects of treatment (worsening cognitive symptoms, increased agitation, worsening insomnia, new suicidal ideation, etc.) should lead to psychiatric consultation.

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# THE ALZHEIMER’S PROJECT

## DICE APPROACH FOR BEHAVIORAL AND PHARMACOLOGIC TREATMENT OF AGITATION & AGGRESSION

## DESCRIBE

<table>
<thead>
<tr>
<th>Verbal Agitation</th>
<th>Physical Agitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aggressive vs Non-Aggressive</td>
<td>• Aggressive vs Non-Aggressive</td>
</tr>
</tbody>
</table>

## INVESTIGATE

<table>
<thead>
<tr>
<th>Agitation Type</th>
<th>Exhibits As</th>
<th>Potential Underlying Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Non-aggressive</td>
<td>Loud Screaming or Moaning, Requests for Help</td>
<td>Depression, Anxiety, Boredom</td>
</tr>
<tr>
<td>Verbal Aggressive</td>
<td>Threats, Name Calling</td>
<td>Paranoia</td>
</tr>
<tr>
<td>Physical Non-Aggressive</td>
<td>Pacing, Repetitive Pounding</td>
<td>Disinhibition, Boredom, Need for Attention, Companionship</td>
</tr>
<tr>
<td>Physical Aggressive</td>
<td>Hitting/Kicking/Pushing</td>
<td>Pain disorder or physical discomfort associated with movement, or constipation</td>
</tr>
</tbody>
</table>

## CREATE

Address physical problems and/or utilize behavioral modifications. For behavioral specific resources: [www.alz.org/care](http://www.alz.org/care)  
The 36 Hour Day by Nancy L. Mace & Peter V. Rabins  
Ensure environment is safe with appropriate stimulation

If treatment of physical problems and/or behavioral modifications do not control behaviors consider pharmacologic treatment — examples:  
- Irritability/depression - antidepressant  
- Fear/paranoia - antipsychotic  
- Disinhibition/embarrassment - mood stabilizer  
- Movement pain - analgesic.

## EVALUATE

*If patient stable 3-6 months, and psychotropic medication has been required, initiate a cautious incremental reduction and monitor patient closely*  
- If symptoms are not fully resolved, look for other underlying causes  
- If intervention not effective or if patient or caregiver are in danger, consider referring to neurologist or psychiatrist.
### DICE APPROACH FOR ASSESSMENT AND TREATMENT OF SLEEP PROBLEMS

<table>
<thead>
<tr>
<th>DESCRIBE</th>
<th>Sundowning</th>
<th>Initial Insomnia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Daytime Sleeping</td>
<td>Middle Insomnia</td>
</tr>
<tr>
<td></td>
<td>Sleep Fragmentation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INVESTIGATE (ASSESS)</th>
<th>Pain</th>
<th>Boredom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Osteoarthritis</td>
<td>Poor Sleep Hygiene</td>
</tr>
<tr>
<td></td>
<td>Sleep Apnea or Orthopnea</td>
<td>Suboptimal Prescribing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CREATE (TREATMENT)</th>
<th>Educate on good sleep hygiene practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Correct any potential medical problems</td>
</tr>
<tr>
<td></td>
<td>If strict application of sleep hygiene practices and successful treatment of all medical co-morbidities has not resolved the insomnia problem, consider insomnia as potential symptoms of a psychiatric disorder and apply the psychobehavioral metaphor. If insomnia appears to be related to temporary/situational factors, consider use of very low dose FDA approved medication for insomnia.*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EVALUATE (AND RE-EVALUATE)</th>
<th>*If patient stable 3-6 months, and psychotropic medication has been required, initiate a cautious incremental reduction and monitor patient closely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• If symptoms are not fully resolved, look for other underlying causes</td>
</tr>
<tr>
<td></td>
<td>• If intervention not effective or if patient or caregiver are in danger, consider referring to geriatric neurologist or psychiatrist</td>
</tr>
</tbody>
</table>

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### DICE APPROACH FOR WANDERING

<table>
<thead>
<tr>
<th>DESCRIBE</th>
<th>Wandering</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May occur in indoor residential or commercial environments as well as outdoor areas with or without secured perimeter</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INVESTIGATE (ASSESS)</th>
<th>Look for patterns, time of day/Sundowning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Common triggers include:</td>
</tr>
<tr>
<td></td>
<td>• Boredom</td>
</tr>
<tr>
<td></td>
<td>• Lack of physical activity</td>
</tr>
<tr>
<td></td>
<td>• Searching for familiar/home</td>
</tr>
<tr>
<td></td>
<td>• Dietary factors: sugar/caffeine</td>
</tr>
<tr>
<td></td>
<td>• Medical factors: pain/constipation</td>
</tr>
<tr>
<td></td>
<td>• Psychiatric issues: anxiety/mania</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CREATE (TREATMENT)</th>
<th>EMPLOY APPROPRIATE BEHAVIORAL AND SAFETY STRATEGIES. IF BEHAVIORAL INTERVENTIONS DO NOT RESOLVE BEHAVIORS: MEDICATION MAY BE NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mania - may need pharmacologic treatment: antipsychotics or mood stabilizers*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EVALUATE (AND RE-EVALUATE)</th>
<th>If wandering persists, look for other underlying causes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• *If patient stable 3-6 months, and psychotropic medication has been required, initiate a cautious incremental reduction and monitor patient closely</td>
</tr>
<tr>
<td></td>
<td>• If intervention not effective or if patient or caregiver are in danger, consider referring to neurologist or psychiatrist</td>
</tr>
</tbody>
</table>
Management of Symptoms of Alzheimer’s Disease and Related Dementia

End of Life Planning and Care

Alzheimer’s Disease is a chronic, progressive, ultimately terminal illness. The time course is generally around 6-10 years from diagnosis to death, but can vary from 3-20 years. Of course, patients may die of other causes or comorbid illnesses during the progression of their dementia. Common causes of death directly related to Alzheimer’s disease are aspiration pneumonia and hypovolemic shock related to cessation of eating and drinking. Alzheimer’s patients may also develop and die from other infections, including UTIs, community- or facility-acquired pneumonias, and infected pressure ulcers. They may also suffer strokes, myocardial infarction, arrhythmias, pulmonary emboli, and other common geriatric conditions.

Advance care planning is very important for patients with Alzheimer’s, and should be undertaken as early as possible after diagnosis—although it is prudent not to bring up that topic simultaneously with sharing the initial diagnosis. Patients who have already formulated advance health care directives (AHCDs) may want to update them, and those who have not completed an AHCD—and who still have decision-making capacity, as with most patients with early Alzheimer’s—should be strongly encouraged to execute such a document immediately. While POLST forms are generally recommended for those in the last year or two of life, patients with early dementia who definitely do not want aggressive interventions like CPR, intubation, de-ribulation or enteral feeding tubes may wish to complete these, and their physicians should insist in this process.

It is important to note that CPR is rarely successful in the frail elderly, and that there is good evidence that feeding tubes are an inappropriate intervention in advanced dementia patients. In spite of that, the 2016 Dartmouth Atlas reported that in San Diego County, we are worse than the national average with respect to placing these tubes inappropriately. References to studies can be found via the Choosing Wisely website (AMDA, AHA/PMI and AGS items at http://www.choosingwisely.org/?s=feeding+tube), and a useful patient education pamphlet is available in multiple languages through the Coalition for Compassionate Care of California (http://coalitionccc.org/tools-resources/decision-guides). In addition to the risks of aspiration pneumonia and complications directly related to the tube (such as intra-abdominal abscesses), feeding tubes are associated with higher rates of delirium and pressure ulcers, and have not been demonstrated to prolong life.

It is worth discussing tube feeding early on and actively discouraging consideration of a feeding tube in an advanced Alzheimer’s patient—despite family concerns about “starvation” and the tendency to associate “food” (nutrition) with nurturing and love. Like all advance care planning discussions, these conversations can be deferred to palliative care specialists, but are meaningful and usually well accepted and appreciated when undertaken by the primary care physician who knows the patient and family best. Thickened liquids and pureed diets, while frequently ordered when dysphagia develops in dementia patient, may not always be appropriate as far as quality of life-risk of aspiration notwithstanding. Consider a palliative medicine referral if there are concerns about these issues.

Another important point to educate patients and families on is the notion of dying from dehydration. At the end of life, patients with dementia and most other illnesses lose interest in food and fluids. It is part of a natural dying process, and dying from dehydration—while it has an unpleasant reputation in the public eye—is actually one of the more benign ways to die. In fact, often no medication for symptom relief (such as opioids or benzodiazepines) is necessary; simple measures like moistening the inside of the mouth often is probably safer than 110/60. Consider stopping all non-essential drugs, especially those that require many years to show benefit. Antipsychotics are dangerous and should be used as a last resort for extreme behavioral or psychotic symptoms (such as frightening hallucinations). Benzodiazepines tend to disinhibit behavior, sometimes exaggerating rather than alleviating anxiety or agitation. They should be avoided whenever possible. As to cholinesterase inhibitors and memantine, they have their own side effects (especially nausea, anorexia and bradycardia for the cholinesterase inhibitors) and are certainly not hugely effective in treating dementia in most patients. Side effects in patients with advanced AD becomes severe, and when the patient is already institutionalized, strong consideration should be given to discontinuing these drugs.

Poor prognostic indicators for Alzheimer’s patients—and a time that may signal appropriateness for a hospice referral—include significant weight loss (e.g., 10% in 6 months), significant (stage 3-4) pressure ulcer development, dysphagia, recurrent upper UTIs or lower respiratory tract infections, marked functional decline (e.g., becoming bedbound), and becoming nonverbal. But hospice can be consulted early, if hospice feels that the patient has more than a six-month life expectancy, they may defer admission but still provide some palliative care guidance.

Finally, the geriatric mantra of de-prescribing should be initiated early and continued diligently. There is little reason for a patient with moderate or severe dementia to be on a statin drug. Anticholinergics (including common drugs for overactive bladder) promote delirium. Sedatives and antidepressants increase the risk of falls. Running a seated blood pressure of 160/90 is probably safer than 110/60.

When you furnish a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service along with the AWV, Medicare may pay for the additional service. Report the additional Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary’s illness or injury, or to improve the functioning of a malformed body member.

Cognitive Examination

Medicare has established a new code in 2018 for services aimed at improving detection, diagnosis, and care planning and coordination for patients with Alzheimer’s disease and related dementias. CPT code 99483, which supersedes the older code G0505, provides reimbursement to physicians and other eligible billing practitioners for a comprehensive clinical visit that results in a written care plan. Code 99483 requires an independent historian; a multidimensional assessment that includes cognition, function, and safety; evaluation of neuropsychiatric and behavioral symptoms; review and reconciliation of medications; and assessment of the needs of the patient’s caregiver. Eligible practitioners must provide documentation that supports a moderate-to-high level of complexity in medical decision making, as defined by E/M guidelines (with application as appropriate of the usual “incident-to” rules, consistent with other E/M services). The provider must also document the detailed care plan developed as a result of each required element covered by 99483. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

The nine assessment elements of 99483 can be evaluated within the care planning visit or in one or more visits that precede it, using appropriate billing codes (most often an E/M code). Patients with complex medical, behavioral, psychosocial and/or caregiving needs may require a series of assessment visits, while those with well-defined or less complex problems may
Management of Symptoms of Alzheimer’s Disease and Related Dementia

be fully assessed during the care plan visit. Results of assessments conducted prior to the care plan visit are allowed in care planning documentation provided they remain valid or are updated with any changes at the time of care planning. A single physician or other qualified health care professional should not report 99483 more than once every 180 days. (See the CPT 2018 manual for full details.)

Advance Care Planning

CPT 99497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

CPT 99498: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure).

You must report a diagnosis code when submitting a claim for ACP as an optional element of an AWV. Since you are not required to document a specific diagnosis code for ACP as an optional element of an AWV, you may choose any diagnosis code consistent with a beneficiary’s exam.

Medicare waives both the coinsurance and the Medicare Part B deductible for ACP when it is:
• Provided on the same day as the covered AWV,
• Furnished by the same provider as the covered AWV,
• Billed with modifier -33 (Preventive Service),
• Billed on the same claim as the AWV.

The deductible and coinsurance for ACP are waived only once per year, when it is billed with the AWV. If the AWV billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP.

Note: The deductible and coinsurance apply when ACP is provided outside the covered AWV.

Resources and References Information

The Clinical Roundtable, along with The County of San Diego Aging and Independence Services Agency, has created a listing of resources which practitioners may provide patients and their caregivers. (See back page, freely copy)

Continuing Medical Education

Primary Care practitioners can take advantage of ongoing professional education on-demand webinars. The courses, provided in partnership with The Doctors Company, are available free of charge and are approved for AMA PRA Category 1 Credits™. The courses are meant to act as training tools, that can be taken at your own convenience in approximately 15-minute segments. You are encouraged to revisit as needed.

Mobile Application for Screening, Diagnosis and Management

The algorithms and instruments included in these guidelines are also available on a mobile application, AlzDxRx, available for free in San Diego for both iOS and Android phones. The app assists physicians to walk through screening and evaluation of patients with cognitive decline while maintaining eye-to-eye contact. Access scoring instruments: MiniCog, AD8, PHQ-9, QDRS, IQCODE, MOCA and SLUMS. Patient identified scores can be emailed for ease in adding to EHR.
Some useful general informational resources include:

Alzheimer's Association http://alz.org
Alzheimer's San Diego http://alzsd.org
Alzheimer's Disease Education and Referral (ADER) http://www.nia.nih.gov/alzheimers
Alzheimer's Drug Discovery Foundation (ADDF) information about risk factors.
https://www.alzdiscovery.org
Gerontological Society of America, KAER Toolkit: 4-Step Process to Detecting Cognitive Impairment and Earlier Diagnosis of Dementia.
American Academy of Neurology
http://www.aan.com
Clinical trials:
Clinicaltrials.gov
https://clinicaltrials.gov/ct2/results?cond=%20Alzheimer%20Disease%20Risk%20Factors
Alzheimer Association Trial finder
http://www.alz.org/research/clinical_trials/findClinicalTrials.trialmatch.aspx
For non-AD disorders:
Levy Body Dementia Association
http://www.lbda.org
Association for Fronto-Temporal Degeneration (AFTD)
http://www.theaftd.org
Screening & Evaluation Instruments
AD8: https://www.alz.org/documents_custom/ad8.pdf

MOCA In English and other languages: http://www.MOCATest.org
PHQ-9 in English and other languages: https://www.communitycareinc.org/provider-tools/conditions/depression/
SUMS Examination in English and other languages: http://www.elderqup.com/sums-dementia-test-available-in-various-languages/
Screening in Chinese population
References: Screening Instruments
http://www.scalesandmeasures.net/files/files/The%20Cornell%20Scale%20for%20Depression%20in%20Dementia.pdf
References: Diagnostic Criteria
http://www.alz.org/documents_custom/Diagnostic_Recommendations_Az_prob.pdf
References: Assessing Cognitive Impairment in Older Patients

Resources and References Information
https://championsforhealth.org/alzheimers
THE ALZHEIMER'S PROJECT
36
https://championsforhealth.org/alzheimers
37
References: Differential Diagnosis, Depression Screening
https://web.stanford.edu/~yesavage/GDS.html


References: Disclosure of Dementia Diagnosis


References: Pharmacotherapy of FDA Approved Medications


References: Non-Pharmacologic Management of Dementia
References: Pharmacologic Management of Dementia


Memantine https://medicineplus.gov/druginfo/meds/a604006.html


Tariot P J Clin Psychiatry 60 (suppl 8):11-20, 1999

References: Identification of IADLs vs ADLs


References: Driving with Dementia


CA.gov: Dementia: https://www.dmv.ca.gov/portal/dmv/shared/driver/clear/driver-safety/dementia


References: End of Life Planning and Care

www.prepareforyourcare.org
www.caringadvocates.org
www.coalitionccc.org
www.theconversationproject.org

References: Elder Abuse

San Diego County:
http://www.sandiegocounty.gov/content/sdchhsa/programs/adult_protective_services.html


California Penal Code 368
https://www.sandiego.gov/police/services/units/elderabuse

San Diego District Attorney
http://www.sdcda.org/helping/elder-abuse.html

References: Capacity Evaluations


References: Driving with Dementia


CA.gov: Dementia: https://www.dmv.ca.gov/portal/dmv/shared/driver/clear/driver-safety/dementia


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http://www.sdcda.org/helping/elder-abuse.html

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References: End of Life Planning and Care

www.prepareforyourcare.org
www.caringadvocates.org
www.coalitionccc.org
www.theconversationproject.org
Mini-Cog™ Instructions for Administration & Scoring

**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.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Banana</td>
<td>Leader</td>
<td>Village</td>
<td>River</td>
<td>Captain</td>
<td>Daughter</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Season</td>
<td>Kitchen</td>
<td>Nation</td>
<td>Garden</td>
<td>Heaven</td>
</tr>
<tr>
<td>Chair</td>
<td>Table</td>
<td>Baby</td>
<td>Finger</td>
<td>Picture</td>
<td>Mountain</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Word Recall</th>
<th>Clock Draw</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0-3 points)</td>
<td>(0 or 2 points)</td>
<td>(0-5 points)</td>
</tr>
</tbody>
</table>

- Word Recall: 1 point for each word spontaneously recalled without cueing.
- Clock Draw: 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. Inability or refusal to draw a clock (abnormal) = 0 points.
- Total Score = Word Recall score + Clock Draw score.

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.

**References**

MINI-COG™ -Spanish

1) OBTENGA LA ATENCIÓN DEL PARTICIPANTE, Y DIGA:
“Le voy a decir tres palabras que quiero que usted recuerde ahora y más tarde. Las palabras son

Por favor, digamelas ahora.”

Manzana  Amanecer  Silla

Intento 1  _________  _________  _________
Intento 2  _________  _________  _________
(ADMINISTRE SOLO SI LAS 3 PALABRAS NO FUERON REPETIDAS EN EL INTENTO 1. Diga “Las palabras son Manzana, Amanecer, Silla. Por favor, digamelas ahora”)

Intento 3  _________  _________  _________
(ADMINISTRE SOLO SI LAS 3 PALABRAS NO FUERON REPETIDAS EN EL INTENTO 2. Diga “Las palabras son Manzana, Amanecer, Silla. Por favor, digamelas ahora”)

(Indíque con una marca de verificación [✓] cada palabra que es repetida correctamente. Dele 3 intentos para repetir las palabras al participante. Si es incapaz de repetir las palabras después de 3 intentos, continúe con el siguiente ítem.)

2) Dele al participante la Página 2 de este formulario y un lápiz/lapicero. DIGA LAS SIGUIENTES FRASES EN EL ORDEN CORRESPONDIENTE:
“Por favor, dibuje un reloj en este espacio. Comience dibujando un círculo grande.”
(Al terminar, diga)
“Coloque todos los números en el círculo.”
(Al terminar, diga)
“Ahora coloque las manecillas del reloj para que marquen las 11 y 10.”

Si el participante no ha terminado de dibujar el reloj en 3 minutos, suspenda este ítem y pídale al participante que le diga las tres palabras que le pidió que recordara antes.

3) DIGA: “¿Cuáles fueron las tres palabras que le pedí que recordara?”

(Puntee 1 por cada una)  Puntaje de las Palabras

Puntee el reloj (según el formulario de Punteo del Reloj):  Puntaje del Reloj

Reloj Normal  2 puntos  Puntaje del Reloj

Reloj Alterado  0 puntos

Puntaje Total = Puntaje de Palabras más Puntaje del Reloj

0, 1, o 2 posible trastorno cognitivo;
3, 4, o 5 indica que no hay trastorno cognitivo

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AD8 Dementia Screening Interview

Patient ID#:__________________________
Date:________________________

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)

5. Forgets correct month or year

6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)

7. Trouble remembering appointments

8. Daily problems with thinking and/or memory

TOTAL AD8 SCORE

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564
Copyright 2005. The AD8 is a copyrighted instrument of the Alzheimer’s Disease Research Center, Washington University, St. Louis, Missouri. All Rights Reserved.
The AD8 Administration and Scoring Guidelines

A spontaneous self-correction is allowed for all responses without counting as an error.

The questions are given to the respondent on a clipboard for self-administration or can be read aloud to the respondent either in person or over the phone. It is preferable to administer the AD8 to an informant, if available. If an informant is not available, the AD8 may be administered to the patient.

When administered to an informant, specifically ask the respondent to rate change in the patient.

When administered to the patient, specifically ask the patient to rate changes in his/her ability for each of the items, without attributing causality.

If read aloud to the respondent, it is important for the clinician to carefully read the phrase as worded and give emphasis to note changes due to cognitive problems (not physical problems). There should be a one second delay between individual items.

No timeframe for change is required.

The final score is a sum of the number items marked “Yes, A change”.

Interpretation of the AD8 (Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564)

A screening test in itself is insufficient to diagnose a dementing disorder. The AD8 is, however, quite sensitive to detecting early cognitive changes associated many common dementing illness including Alzheimer disease, vascular dementia, Lewy body dementia and frontotemporal dementia.

Scores in the impaired range (see below) indicate a need for further assessment. Scores in the “normal” range suggest that a dementing disorder is unlikely, but a very early disease process cannot be ruled out. More advanced assessment may be warranted in cases where other objective evidence of impairment exists.

Based on clinical research findings from 995 individuals included in the development and validation samples, the following cut points are provided:

- 0 – 1: Normal cognition
- 2 or greater: Cognitive impairment is likely to be present

Administered to either the informant (preferable) or the patient, the AD8 has the following properties:

- Sensitivity > 84%
- Specificity > 80%
- Positive Predictive Value > 85%
- Negative Predictive Value > 70%
- Area under the Curve: 0.908; 95%CI: 0.888-0.925

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### AD8 Dementia Screening Interview

**Recuerde:** “Sí. Hay cambios.” significa que ha habido un cambio en los últimos años debido a problemas cognitivos (pensamiento y memoria).

<table>
<thead>
<tr>
<th>Sí.</th>
<th>No.</th>
<th>No aplicable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hay cambios</td>
<td>1 punto</td>
<td>0 punto</td>
</tr>
</tbody>
</table>

**1. Problemas de juicio (ejemplo: compra regalos inadecuados, ha sido estafado/a, toma malas decisiones en lo económico)**

<table>
<thead>
<tr>
<th></th>
<th>1 punto</th>
<th>0 punto</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>SÍ.</td>
<td>NO.</td>
</tr>
<tr>
<td></td>
<td>1 punto</td>
<td>0 punto</td>
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</tbody>
</table>

**2. Menor interés en realizar actividades o sus pasatiempos**

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<th>0 punto</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>SÍ.</td>
<td>NO.</td>
</tr>
<tr>
<td></td>
<td>1 punto</td>
<td>0 punto</td>
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</tbody>
</table>

**3. Repite las preguntas, historias**

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<tbody>
<tr>
<td></td>
<td>SÍ.</td>
<td>NO.</td>
</tr>
<tr>
<td></td>
<td>1 punto</td>
<td>0 punto</td>
</tr>
</tbody>
</table>

**4. Tiene dificultad para aprender a usar instrumentos tecnológicos, electrodomésticos (como el control remoto TV, computador, microondas, video grabadora)**

<table>
<thead>
<tr>
<th></th>
<th>1 punto</th>
<th>0 punto</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SÍ.</td>
<td>NO.</td>
</tr>
<tr>
<td></td>
<td>1 punto</td>
<td>0 punto</td>
</tr>
</tbody>
</table>

**5. Olvida el mes o año**

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<th>1 punto</th>
<th>0 punto</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>SÍ.</td>
<td>NO.</td>
</tr>
<tr>
<td></td>
<td>1 punto</td>
<td>0 punto</td>
</tr>
</tbody>
</table>

**6. Tiene dificultad en el manejo de asuntos nancieros complejos (pagar las cuentas, llevar la chequera, pago de impuestos)**

<table>
<thead>
<tr>
<th></th>
<th>1 punto</th>
<th>0 punto</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SÍ.</td>
<td>NO.</td>
</tr>
<tr>
<td></td>
<td>1 punto</td>
<td>0 punto</td>
</tr>
</tbody>
</table>

**7. Tiene dificultad para acordarse de los compromisos (citadas al doctor etc.)**

<table>
<thead>
<tr>
<th></th>
<th>1 punto</th>
<th>0 punto</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SÍ.</td>
<td>NO.</td>
</tr>
<tr>
<td></td>
<td>1 punto</td>
<td>0 punto</td>
</tr>
</tbody>
</table>

**8. Problema persistente de memoria y pensamiento (no ocasional)**

<table>
<thead>
<tr>
<th></th>
<th>1 punto</th>
<th>0 punto</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SÍ.</td>
<td>NO.</td>
</tr>
<tr>
<td></td>
<td>1 punto</td>
<td>0 punto</td>
</tr>
</tbody>
</table>

**TOTAL AD8 SCORE**

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### INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (IADL)

**M.P. Lawton & E.M. Brody**

**A. Ability to use telephone**

1. Operates telephone on own initiative; looks up and dials numbers, etc. 1
2. Dials a few well-known numbers 1
3. Answers telephone but does not dial 1
4. Does not use telephone at all. 0

**B. Shopping**

1. Takes care of all shopping needs independently 1
2. Shops independently for small purchases 0
3. Needs to be accompanied on any shopping trip. 0
4. Completely unable to shop. 0

**C. Food Preparation**

1. Plans, prepares and serves adequate meals independently 1
2. Prepares adequate meals if supplied with ingredients 0
3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet. 0
4. Needs to have meals prepared and served. 0

**D. Housekeeping**

1. Maintains house alone or with occasional assistance (e.g. “heavy work domestic help”) 1
2. Performs light daily tasks such as dishwashing, bed making 1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness. 1
4. Needs help with all home maintenance tasks. 1
5. Does not participate in any housekeeping tasks. 0

**E. Laundry**

1. Does personal laundry completely 1
2. Launders small items; rinses stockings, etc. 1
3. All laundry must be done by others. 0

**F. Mode of Transportation**

1. Travels independently on public transportation or drives own car. 1
2. Arranges own travel via taxi, but does not otherwise use public transportation. 1
3. Travels on public transportation when accompanied by another. 1
4. Travel limited to taxi or automobile with assistance of another. 0
5. Does not travel at all. 0

**G. Responsibility for own medications**

1. Is responsible for taking medication in correct dosages at correct time. 1
2. Takes responsibility if medication is prepared in advance in separate dosage. 0
3. Is not capable of dispensing own medication. 0

**H. Ability to Handle Finances**

1. Manages financial matters independently (budgets, writes checks, pays rent, bills goes to bank), collects and keeps track of income. 1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc. 1
3. Incapable if handling money. 0

---


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### Instruments 2: Evaluation Instruments

#### The QDRS, Quick Dementia Rating System

<table>
<thead>
<tr>
<th>0</th>
<th>No obvious memory loss or inconsistent forgetfulness that does not interfere with function in everyday activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>Consistent mild forgetfulness or partial recollection of events that may interfere with performing everyday activities; repeats questions/statements, misplaces items, forgets appointments</td>
</tr>
<tr>
<td>1</td>
<td>Mild to moderate memory loss; more noticeable for recent events; interferes with performing everyday activities</td>
</tr>
<tr>
<td>2</td>
<td>Moderate to severe memory loss; only highly learned information remembered; new information rapidly forgotten</td>
</tr>
</tbody>
</table>

#### Socially appropriate behavior in public and private; no changes in personality

<table>
<thead>
<tr>
<th>0</th>
<th>No changes in mood, interest, or motivation level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>Occasional sadness, depression, anxiety, nervousness, or loss of interest/motivation</td>
</tr>
<tr>
<td>1</td>
<td>Daily mild issues with sadness, depression, anxiety, nervousness, or loss of interest/motivation</td>
</tr>
<tr>
<td>2</td>
<td>Moderate issues with sadness, depression, anxiety, nervousness, or loss of interest/motivation</td>
</tr>
<tr>
<td>3</td>
<td>Severe issues with sadness, depression, anxiety, nervousness, or loss of interest/motivation</td>
</tr>
</tbody>
</table>

**Total of B Scores**

A total score of ≥ 2 suggests a problem causing limitations or issues, and may need a detailed workup.

**Cognitive subtotal (questions 1, 2, 3, 8) Total of C Scores**

**Behavioral subtotal (questions 4, 5, 6, 7, 9, 10) Total of B Scores**

**Total QDRS score**
Montreal Cognitive Assessment (MoCA)  
Version 8.1  

Administration and Scoring Instructions

The Montreal Cognitive Assessment (MoCA) was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuocconstructional skills, conceptual thinking, calculations, and orientation. The MoCA may be administered by anyone who understands and follows the instructions, however, only a health professional with expertise in the cognitive field may interpret the results. Time to administer the MoCA is approximately 10 minutes. The total possible score is 30 points; a score of 26 or above is considered normal.

All instructions may be repeated once.

1. Alternating Trail Making:

Administration: The examiner instructs the subject: "Please draw a line going from a number to a letter in ascending order. Begin here [point to (1)] and draw a line from 1 then to A then to 2 and so on. End here [point to (E)]."

Scoring: One point is allocated if the subject successfully draws the following pattern: 1- A- 2- B- 3- C- 4- D- 5- E, without drawing any lines that cross. Any error that is not immediately self-corrected (meaning corrected before moving on to the Cube task) earns a score of 0. A point is not allocated if the subject draws a line to connect the end (E) to the beginning (1).

2. Visuoconstructional Skills (Cube):

Administration: The examiner gives the following instructions, pointing to the cube:

"Copy this drawing as accurately as you can."

Scoring: One point is allocated for a correctly executed drawing.

• Drawing must be three-dimensional.
• All lines are drawn.
• All lines meet with little or no space.
• No line is added.
• Lines are relatively parallel and their length is similar (rectangular prisms are accepted).
• The cube’s orientation in space must be preserved.

A point is not assigned if any of the above criteria is not met.

3. Visuoconstructional Skills (Clock):

Administration: The examiner must ensure that the subject does not look at his/her watch while performing the task and that no clocks are in sight. The examiner indicates the appropriate space and gives the following instructions: "Draw a clock. Put in all the numbers and set the time to 10 past 11."

Scoring: One point is allocated for each of the following three criteria:

• Contour (1 pt.): the clock contour must be drawn (either a circle or a square). Only minor distortions are acceptable (e.g., slight imperfection on closing the circle). If the numbers are arranged in a circular manner but the contour is not drawn the contour is scored as incorrect.
• Numbers (1 pt.): all clock numbers must be present with no additional numbers. Numbers must be in the correct order, upright and placed in the approximate quadrants on the clock face. Roman numerals are acceptable. The numbers must be arranged in a circular manner (even if the contour is a square). All numbers must either be placed inside or outside the clock contour. If the subject places some numbers inside the clock contour and some outside the clock contour, (s)he does not receive a point for Numbers.
• Hands (1 pt.): there must be two hands jointly indicating the correct time. The hour hand must be clearly shorter than the minute hand. Hands must be centered within the clock face with their junction close to the clock center.

4. Naming:

Administration: Beginning on the left, the examiner points to each figure and says: “Tell me the name of this animal.”

Scoring: One point is given for each of the following responses: (1) lion (2) rhinoceros or rhino (3) camel or dromedary.

5. Memory:

Administration: The examiner reads a list of five words at a rate of one per second, giving the following instructions: “This is a memory test. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn’t matter in what order you say them.” The examiner marks a check in the allocated space for each word the subject produces on this first trial. The examiner may not correct the subject if (s)he recalls a deformed word or a word that sounds like the target word. When the subject indicates that (s)he has finished (has recalled all words), or can recall no more words, the examiner reads the list a second time with the following instructions: “I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time.” The examiner puts a check in the allocated space for each word the subject recalls on the second trial. At the end of the second trial, the examiner informs the subject that (s)he will be asked to recall these words again by saying: ‘I will ask you to recall those words again at the end of the test.’

Scoring: No points are given for Trials One and Two.

6. Attention:

Forward Digit Span: Administration: The examiner gives the following instructions: “I am going to say some numbers and when I am through, repeat them to me exactly as I said them.” The examiner reads the five number sequence at a rate of one digit per second.

Backward Digit Span: Administration: The examiner gives the following instructions: “Now I am going to say some more numbers, but when I am through you must repeat
them to me in the backward order.” The examiner reads the three number sequence at a rate of one digit per second. If the subject repeats the sequence in the forward order, the examiner may not ask the subject to repeat the sequence in backward order at this point.

Scoring: One point is allocated for each sequence correctly repeated. (N.B.: the correct response for the backward trial is 2-4-7).

Vigilance: Administration: The examiner reads the list of letters at a rate of one per second, after giving the following instructions: “I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand.”

Scoring: One point is allocated if there is zero to one error (an error is a tap on a wrong letter or a failure to tap on letter A).

Serial 7s: Administration: The examiner gives the following instructions: “Now, I will ask you to count by subtracting 7 from 100, and then, keep subtracting 7 from your answer until I tell you to stop.” The subject must perform a mental calculation, therefore, (s)he may not use his/her fingers nor a pencil and paper to execute the task. The examiner may not repeat the subject’s answers. If the subject asks what her/his last given answer was or what number (s)he must subtract from his/her answer, the examiner responds by repeating the instructions if not already done so.

Scoring: This item is scored out of 3 points. Give no (0) points for no correct subtractions, 1 point for one correct subtraction, 2 points for two or three correct subtractions, and 3 points if the subject successfully makes four or five correct subtractions. Each subtraction is evaluated independently: that is, if the subject responds with an incorrect number but continues to correctly subtract 7 from it, each correct subtraction is counted. For example, a subject may respond “92 – 85 – 78 – 71 – 64” where the “92” is incorrect, but all subsequent numbers are subtracted correctly. This is one error and the task would be given a score of 3.

7. Sentence repetition:

Administration: The examiner gives the following instructions: “I am going to read you a sentence. Repeat it after me, exactly as I say it [pause]. I only know that John is the one to help today.” Following the response, say: “Now I am going to read you another sentence. Repeat it after me, exactly as I say it [pause]. The cat always hid under the couch when dogs were in the room.”

Scoring: One point is allocated for each sentence correctly repeated. Reiterations must be exact. Be alert for omissions (e.g., omitting “only”), substitutions/additions (e.g., substituting “only” for “always”), grammar errors/altering plurals (e.g. “hides” for “hid”), etc.

8. Verbal fluency:

Administration: The examiner gives the following instructions: “Now, I want you to tell me as many words as you can think of that begin with the letter F. I will tell you to stop after one minute. Proper nouns, numbers, and different forms of a verb are not permitted. Are you ready? [Pause] [Time for 60 sec.] Stop.” If the subject names two consecutive words that begin with another letter of the alphabet, the examiner repeats the target letter if the instructions have not yet been repeated.

Scoring: One point is allocated if the subject generates 11 words or more in 60 seconds. The examiner records the subject’s responses in the margins or on the back of the test sheet.

9. Abstraction:

Administration: The examiner asks the subject to explain what each pair of words has in common, starting with the example: “I will give you two words and I would like you to tell me to what category they belong to [pause]; an orange and a banana.” If the subject responds correctly the examiner replies: “Yes, both items are part of the category Fruits.” If the subject answers in a concrete manner, the examiner gives one additional prompt: “Tell me another category to which these items belong to.” If the subject does not give the appropriate response (fruits), the examiner says: “Yes, and they also both belong to the category Fruits.” No additional instructions or clarifications are given.

After the practice trial, the examiner says: “Now, a train and a bicycle.” Following the response, the examiner administers the second trial by saying: “Now, a ruler and a watch.” A prompt (one for the entire abstraction section) may be given if none was used during the example.

Scoring: Only the last two pairs are scored. One point is given for each pair correctly answered. The following responses are acceptable:
- “train-bicycle = means of travelling, means of travelling,
- “ruler-watch = measuring instruments, used to measure
The following responses are not acceptable:
- “train-bicycle = they have wheels
- “ruler-watch = they have numbers

10. Delayed recall:

Administration: The examiner gives the following instructions: “I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember.” The examiner makes a check mark (✓) for each of the words correctly recalled spontaneously without any cues, in the allocated space.

Scoring: One point is allocated for each word recalled freely without any cues.

Memory index score (MIS):

Administration: Following the delayed free recall trial, the examiner provides a category (semantic) cue for each word the subject was unable to recall. Example: “I will give you some hints to see if it helps you remember the words; the first word was a body part.” If the subject is unable to recall the word with the category cue, the examiner provides him/her with a multiple choice cue. Example: “Which of the following words do you think it was, NOSE, FACE, or HAND?” All non-recalled words are prompted in this manner. The examiner identifies the words the subject was able to recall with the help of a cue (category or multiple-choice) by placing a check mark (✓) in the appropriate space. The cues for each word are presented below:
Please refer to the MoCA website at www.mocatest.org for more information on the MoCA.
Montreal Cognitive Assessment [Evaluación Cognitiva Montreal (MoCA)]
Versión 8.1

Instrucciones para la administración y puntuación de los resultados

La Evaluación Cognitiva Montreal (Montreal cognitive assessment / MoCA) ha sido concebida para evaluar las disfunciones cognitivas leves. Este instrumento examina las siguientes habilidades: atención, concentración, funciones ejecutivas (incluyendo la capacidad de abstracción), memoria, lenguaje, capacidades visuoconstructivas, cálculo y orientación. Cualquier persona que comprenda y siga sus instrucciones puede administrar el MoCA, si bien únicamente un profesional de la salud especialista en el ámbito cognitivo podrá interpretar sus resultados. El tiempo de administración requerido es de aproximadamente diez minutos. La puntuación máxima es de 30; una puntuación igual o superior a 26 se considera normal.

Todas las instrucciones pueden repetirse una vez.

1. Alternancia conceptual:

Administración. El examinador da las instrucciones siguientes: "Me gustaría que dibujara una línea alternando entre cifras y letras, respetando el orden numérico y el orden alfabético. Comience aquí (señale el 1) y dibuje una línea desde el 1 hasta la letra A y, a continuación, de la A hacia el 2 y así sucesivamente. Termine aquí (señale la E)".

Puntuación. Se asigna un punto si el paciente realiza la siguiente secuencia: 1 – A – 2 – B – 3 – C – 4 – D – 5 – E, sin que ninguna línea se cruce. Si la persona no se autocorrege inmediatamente después de cometer un error, es decir, no lo corrije antes de pasar a la parte del cubo, la puntuación debe ser 0. No se asignará ningún punto si la persona dibuja una línea conectando el final (E) con el principio (1).

2. Capacidades visuoconstructivas (Cubo):

Administración. El examinador da las instrucciones siguientes, señalando el cubo: "Me gustaría que copiara este dibujo de la manera más precisa posible".

Puntuación. Se asigna un punto si se realiza el dibujo correctamente.
• El dibujo debe ser tridimensional.
• Todas las líneas están presentes.
• Sin espacios o con poco espacio entre las líneas.
• No se añaden líneas.
• Las líneas son relativamente paralelas y aproximadamente de la misma longitud (los prismas rectangulares son aceptables)
• Debe mantenerse la orientación espacial del cubo.

No se asigna ningún punto si no se han cumplido todos los criterios anteriores.

3. Capacidades visuoconstructivas (Reloj):

Administración. El examinador debe asegurarse de que la persona no mira el reloj mientras realiza la tarea y de que no hay ningún reloj a la vista. El examinador señala el espacio adecuado y da las instrucciones siguientes: "Dibuje un reloj. Incluya todos los números y dibuje señalando las 11 y 10 minutos".

Puntuación. Se asigna un punto por cada uno de los tres criterios siguientes:
• Contorno (1 pt.): Debe dibujar el contorno del reloj, ya sea un círculo o un cuadrado,
• Capacidad de ubicación del reloj en el plano (2 pts.): Debe colocar el reloj en el plano de una manera que sea claramente reconocible.
• Precisión de los números (3 pts.): Debe dibujar los números correctamente en el reloj.

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solo se aceptarán leves deformaciones, por ejemplo, alguna imperfección al cerrar el círculo. Si los números están dispuestos en círculo pero no se ha dibujado el contorno, este se considerará incorrecto.

- Números (1 pt.): Todos los números deben estar presentes, sin añadir ninguno; Los números deben seguir el orden correcto, estar bien colocados y situados aproximadamente en su cuadrante del reloj. Se aceptarán los números romanos. Los números deben estar dispuestos en círculo, aunque el contorno sea cuadrado. Todos los números deben estar situados dentro o fuera del contorno del reloj. Si la persona sitúa algunos números dentro del contorno del reloj y algunos fuera del contorno, no se le asignará ningún punto por Números.

- Áigas (1 pt.): Las dos áigas deben indicar la hora correcta. La aguja de las horas debe ser claramente más corta que la de los minutos. Las áigas deben estar centradas dentro de la esfera del reloj y su punto de unión debe estar cerca del centro del reloj.

4. Identificación:

- Administración: El examinador señala cada dibujo, empezando por la izquierda, y dice: “Dígame el nombre de este animal”.

- Puntuación: Se asigna un punto por cada una de las siguientes respuestas: (1) león (2) rinoceronte (3) camelio o dromedario.

5. Memoria:

- Administración: El examinador lee una lista de cinco palabras a un ritmo de una palabra por segundo, tras dar las siguientes instrucciones: “Esta es una prueba de memoria. Le voy a leer una lista de palabras que debe recordar. Escuche con atención. Cuando acabe, digame todas las palabras que pueda recordar. No importa el orden en el que me las diga”. El examinador deberá marcar con una cruz, en el espacio reservado a dicho efecto, todas las palabras que el paciente repita en este primer intento. El examinador no debe corregir al paciente si este recuerda mal una palabra o dice una palabra que se parece a la correcta. Cuando el paciente diga que ya ha terminado (se haya acordado de todas las palabras) o cuando no pueda acordarse de más palabras, el examinador volverá a leer la lista de palabras tras dar las instrucciones siguientes: “Ahora le voy a leer la misma lista de palabras una vez más. Intente acordarse del mayor número posible de palabras, incluyendo las que repitió en la primera ronda”. El examinador marcará con una cruz, en el espacio reservado a dicho efecto, todas las palabras que el paciente repita en el segundo intento. Al final del segundo intento, el examinador informará al paciente de que debe recordar estas palabras diciendo: “Le volveré a preguntar estas palabras al final de la prueba”.

- Puntuación: En los intentos 1 y 2 no se darán puntos.

6. Atención:

- Administración de Serie de números hacia delante. El examinador dará las siguientes instrucciones: “Le voy a leer una serie de números y, cuando haya terminado, deberá repetirlos en el mismo orden en el que yo los he dicho”. El examinador lee una secuencia de cinco números a un ritmo de uno por segundo.

- Puntuación. Se asigna un punto por cada una de las secuencias repetidas correctamente (nota: el orden exacto de la secuencia numérica inversa es 2-4-7).

7. Repetición de frases:

- Administración: El examinador dará las instrucciones siguientes: “Ahora le voy a leer una frase. Repítala exactamente cuando yo termine [pausa]: ‘Solo sé que le toca a Juan ayudar hoy’”. Después de la respuesta, diga: “Ahora le voy a leer otra frase. Repítala exactamente cuando yo termine [pausa]: ‘El gato siempre se esconde debajo del sofá cuando hay perros en la habitación’”.

- Puntuación: Se asigna un punto por cada frase repetida correctamente. La repetición debe ser exacta. Se debe prestar atención a los errores de omisión (p.ej., olvidar “solo”), sustitución/adición (p.ej., sustituir “solo” por “siempre”), errores gramaticales/plurales incorrectos (p.ej. “se esconde” por “se escondía”), etc.

8. Fluidez verbal:

- Administración: El examinador dará las instrucciones siguientes: “Ahora, diga el mayor número posible de palabras que comienzan por la letra F. Le pediré que pare al minuto. No se permiten nombres, números y las formas conjugadas de un verbo. ¿Está preparado [Pausa] [Tiempo 60 segundos] Pare”. Si el paciente nombra dos palabras seguidas que empiezan con otra letra del abecedario, deberá repetirle la letra correcta si aún no le ha repetido las instrucciones.

- Puntuación: Se asigna un punto si el paciente dice 11 palabras o más en un minuto. El examinador anotará las respuestas del paciente en el margen o en el reverso de la hoja del test.
9. Abstracción: 
Administración. El examinador pedirá al paciente que le explique qué tienen en común cada pareja de palabras, ilustrándolo con el ejemplo siguiente: “Le diré dos palabras y me gustaría que usted me dijera a qué categoría pertenecen [pausa]: una naranja y un plátano”. Si el paciente da la respuesta correcta, el examinador deberá decir: “Sí, las dos pertenecen a esta categoría de frutas”. Si el paciente responde de una manera concreta, el examinador deberá ofrecerle una pista adicional: “Digame otra categoría a la que también puedan pertenecer estas cosas”. Si el paciente no da la respuesta correcta (frutas), el examinador deberá decir: “Sí y las dos pertenecen también a la categoría de frutas”. No de otras instrucciones o explicaciones. 

Tras el primer intento de prueba, el examinador deberá decir: “Ahora, un tren y una bicicleta”. Tras la respuesta, el examinador administrará el segundo intento diciendo: “Ahora, una regla y un reloj”. Podrá ofrecerse una pista (una sola para todo el apartado de abstracción) si no se ha dado ninguna en el primer ejemplo.

Puntuación. Solo se puntuarán los dos últimos pares. Se asigna un punto por cada par correcto. Se aceptan las siguientes respuestas:  
- tren/bicicleta = medios de transporte, medios de locomoción, para viajar  
- regla/reloj = instrumentos de medición, para medir  
Las siguientes respuestas no son aceptables:  
- tren/bicicleta = tienen ruedas  
- regla/reloj = tienen números

10. Recuerdo diferido
Administración. El examinador pedirá al paciente que le explique qué tienen en común cada una de las palabras recordadas espontáneamente, sin pistas.

Puntuación. Se asigna un punto por cada una de las palabras recordadas espontáneamente, sin pistas.

<table>
<thead>
<tr>
<th>Palabra correcta</th>
<th>Pista de categoría</th>
<th>Elección múltiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROSTRO</td>
<td>parte del cuerpo</td>
<td>nariz, rostro, mano (hombro, pierna)</td>
</tr>
<tr>
<td>SEDA</td>
<td>tipo de tela</td>
<td>tela vaquera, seda, algodón (nylon, terciopelo)</td>
</tr>
<tr>
<td>TEMPLE</td>
<td>tipo de edificio</td>
<td>templo, escuela, hospital (biblioteca, tienda)</td>
</tr>
<tr>
<td>CLAVEL</td>
<td>tipo de flor</td>
<td>rosa, clavel, tulipán (azucena, margarita)</td>
</tr>
<tr>
<td>ROJO</td>
<td>color</td>
<td>rojo, azul, verde (amarillo, morado)</td>
</tr>
</tbody>
</table>

* Las palabras entre paréntesis se usarán si el paciente menciona una o dos de las respuestas de elección múltiple cuando se le dé la pista de la categoría.

Puntuación. Para determinar el MIS (que es una subpuntuación), el examinador asignará puntos según el tipo de recuerdo (véase tabla más abajo). El uso de las pistas proporciona información clínica sobre la naturaleza de los déficits de memoria. Cuando se trata de déficits de memoria a causa de un recuerdo fallido, el rendimiento puede mejorarse gracias a las pistas. Cuando se trata de déficits de memoria a causa de fallos de codificación, las pistas no mejoran el rendimiento.

<table>
<thead>
<tr>
<th>Puntuación MIS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Número de palabras recordadas espontáneamente multiplicado por 3</td>
<td>...</td>
</tr>
<tr>
<td>Número de palabras recordadas con una pista de la categoría multiplicado por 2</td>
<td>...</td>
</tr>
<tr>
<td>Número de palabras recordadas con pistas de elección multiplicado por 1</td>
<td>...</td>
</tr>
</tbody>
</table>

Total MIS (sumar todos los puntos) = ---/15

11. Orientación:

Administración. El examinador pedirá al paciente que le explique cómo se llama este lugar y en qué localidad nos encontramos. Si el paciente no responde en consecuencia y el examinador no le apunta una respuesta, el examinador dará la siguiente pista: “Ahora, digame cómo se llama este lugar y en qué localidad nos encontramos”.

Puntuación. Se asigna un punto por cada una de las respuestas correctas. La fecha y el lugar (nombre del hospital, clínica, consulta) deben ser exactos. No se asignará ningún punto si el paciente se equivoca por un día en el día del mes y de la semana.

PUNTUACIÓN TOTAL. Sume todos los puntos obtenidos en el margen derecho de la hoja. Añada un punto si el paciente tiene 12 años o menos de estudios, hasta un máximo de 30 puntos. Una puntuación igual o superior a 26 se considera normal.

Por favor, consulte la web del MoCA www.mocatest.org para más información sobre el MoCA.
**MONTREAL COGNITIVE ASSESSMENT (MOCA®)**
(EVALUACIÓN COGNITIVA MONTREAL)

**Nombre:** ________________
**Fecha de nacimiento:** ________________
**Versión:** 8.1 Spanish (Spain)

---

**VISUOESPACIAL / EJECUTIVA**

Copiar el cubo

Dibujar un RELOJ (Once y diez)

6 puntos

**Nivel de estudios:** ________________

---

**IDENTIFICACIÓN**

Nombre: ________________
Fecha de nacimiento: ________________
Sexo: ________________

---

**MEMORIA**

Lea la lista de palabras, el paciente debe repetirlas. Haga dos intentos. Recuérdelas 5 minutos más tarde.

ROSTRO  SEDA  TEMPLO  CLAVEL  ROJO

1º INTENTO  __________  __________  __________  __________  __________
2º INTENTO  __________  __________  __________  __________  __________

---

**ATENCIÓN**

Lea la serie de números (1 número/lugar).

El paciente debe repetirlos en el mismo orden.

1-2-3-4-5-6

1º INTENTO  __________  __________  __________  __________  __________
2º INTENTO  __________  __________  __________  __________  __________

---

**LENGUAJE**

Fluidez del lenguaje. Déjela en blanco si no tiene errores.

De decir el mayor número posible de palabras que comiencen por la letra “F” en 1 minuto.

____ (N ≥ 11 palabras)

---

**ABSTRACIÓN**

Semejanzas entre ejemplos: plátano - naranja = fruta

- tren - bicicleta

---

**RECUERDO DIFERIDO**

Debe recordar las palabras SIN DÁRLE PISTAS.

ROSTRO  SEDA  TEMPLO  CLAVEL  ROJO

Puntos por recordar: 0 pistas = __________

---

**ORIENTACIÓN**

Fecha  __________  Mes  __________  Año  __________  Día de la semana  __________  Lugar  __________  Localidad  __________

---

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MIS: __________ / 15

---

THE ALZHEIMER’S PROJECT

https://championsforhealth.org/alzheimers

THE ALZHEIMER’S PROJECT

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**VAMC SLUMS Examination**

Questions about this assessment tool? E-mail aging@slu.edu.

---

1. What day of the week is it?
2. What is the year?
3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
6. How much did you spend?
7. How much do you have left?
8. Please name as many animals as you can in one minute.
9. What were the five objects I asked you to remember? I point for each one correct.
10. I am going to give you a series of numbers and I would like you to give them to me backwards.
11. I am going to tell you a story. Please listen carefully because afterwards, I’m going to ask you some questions about it.
12. What was the female’s name?
13. What work did she do?
14. When did she go back to work?
15. What state did she live in?

**TOTAL SCORE**

---

**Department of Veterans Affairs**

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**SAINT LOUIS UNIVERSITY**

---

**HIGH SCHOOL EDUCATION**

<table>
<thead>
<tr>
<th>GRADUATION YEAR</th>
<th>MIS</th>
<th>MIS ≤ 26/30</th>
</tr>
</thead>
<tbody>
<tr>
<td>27-30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-20</td>
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<td></td>
</tr>
</tbody>
</table>

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**LESS THAN HIGH SCHOOL EDUCATION**

<table>
<thead>
<tr>
<th>GRADUATION YEAR</th>
<th>MIS</th>
<th>MIS ≤ 26/30</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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© Mild Neurocognitive Disorder

VAMC
SLUMS Examination

Name:   ID:   Age:   Date Given:

Educ: Alert?

1. ¿Qué día de la semana es hoy? __________ 
2. En qué año estamos? __________ 
3. En qué estado estamos? __________ 
4. Por favor, recuerde los cinco objetos que le voy a nombrar. Más tarde, le preguntaré nuevamente por ellos.
5. Usted tiene ciento dolares, y en la tienda compra una docena de manzanas por tres dolares y una bicicleta por veinte dolares. Cuánto dinero gastó? __________
6. Por favor en un minuto nombre todos los animales que pueda.
0-4 animals 5-9 animals 10-14 animals 15+ animals
7. Cuáles fueron los 5 objetos que le dije que recordara?
8. Voy a decirle una serie de números. Me gustaría que usted me los dijera al revés. Por ejemplo, si yo digo 42, usted debe decir 24.
9. Este círculo representa un reloj. Por favor escriba los números de las horas y las manecillas señalando las once menos diez.
10a. Por favor, señale el triángulo con una equis.
10b. Cuál de estas figuras es la más grande?
11. Voy a contarle una historia. Por favor, escuche cuidadosamente, porque al terminar le voy a hacer unas preguntas sobre esta historia.

Maria era una abogada muy exitosa y ganaba mucho dinero en la compañía donde trabajaba. Ella conoció a Carlos, un hombre muy apuesto, y, al cabo del tiempo, se casaron, tuvieron 3 hijos y vivían en Chicago. Ella dejó de trabajar para criar a sus hijos, y cuando estos fueron adolescentes ella volvió al trabajo. Ella y Carlos vivieron felices por siempre.

To score the IQCODE, add up the score for each question and divide by the number of questions. For the short IQCODE, divide by 16. The result is a score that ranges from 1 to 5. A score of 3 means that the subject is rated on average as 'no change'. A score of 4 means an average of 'a bit worse'. A score of 5 an average of 'much worse'. For the short IQCODE, a cutting point of 3.31/3.38 achieves a balance of sensitivity and specificity.
CRIBADO DE DEMENCIAS - TEST DEL INFORMADOR -

Población diana: Población informante clave de una persona con sospecha de deterioro cognitivo. Se trata de un test autoadministrado.

Instrucciones para el informante clave:
Recuerde, por favor, cómo era su familiar hace 5 ó 10 años y compare cómo es él en este momento. Conteste si ha habido algún cambio a lo largo de este tiempo en la capacidad de su familiar para cada uno de los aspectos que le preguntamos. Puntúe con los siguientes criterios:

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacidad para reconocer las caras de sus personas más íntimas (parientes, amigos)</td>
<td>Ha mejorado mucho</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacidad para recordar los nombres de estas mismas personas</td>
<td>Ha mejorado un poco</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recordar las cosas de esas personas (dónde viven, de qué viven, cuándo es su cumpleaños)</td>
<td>Ha empeorado un poco</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recordar cosas que han ocurrido recientemente, en los últimos 2 o 3 meses (noticias, cosas suyas o de sus familiares)</td>
<td>Ha empeorado mucho</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recordar lo que habló en una conversación unos días antes</td>
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<tr>
<td>Olvidar lo que se ha dicho unos minutos antes, pararse a la mitad de una frase y no saber lo que iba a decir, repetir lo que ha dicho antes</td>
<td></td>
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<tr>
<td>Recordar su propia dirección o número de teléfono</td>
<td></td>
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<tr>
<td>Recordar la fecha en que vive</td>
<td></td>
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</tr>
<tr>
<td>Conocer el sitio exacto de los armarios de su casa y dónde se guardan las cosas</td>
<td></td>
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<td></td>
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<tr>
<td>Saber dónde se pone una cosa que se ha encontrado descolocada</td>
<td></td>
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<tr>
<td>Adaptarse a la situación cuando su rutina diaria se ve alterada (ir de visita, en alguna celebración, de vacaciones)</td>
<td></td>
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</tr>
<tr>
<td>Saber manejar los aparatos de la casa (teléfono, coche, lavadora, máquina de afeitar, etc.)</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Capacidad para aprender a manejar un aparato nuevo (lavadora, tocadiscos, radio, secador de pelo, etc.)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

ITEMS

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recordar las cosas que han sucedido recientemente (en general)</td>
<td>Ha mejorado mucho</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aprender cosas nuevas (en general)</td>
<td>Ha mejorado un poco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacidad para recordar cosas que ocurrieron o que aprendió cuando era joven</td>
<td>Casi sin cambios</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprender el significado de palabras poco corrientes (del periódico, televisión, conversación)</td>
<td>Ha empeorado un poco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entender artículos de periódicos o revistas en las que está interesado</td>
<td>Ha empeorado mucho</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seguir una historia del libro, la prensa, el cine, la radio o la televisión</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redactar cartas a parientes o amigos o cartas de negocios</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recordar gentes y hechos históricos del pasado (guerra civil, república, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tomar decisiones tanto en cuestiones cotidianas (qué traje ponerse, qué comida preparar) como en asuntos a más largo plazo (dónde ir de vacaciones o invertir el dinero)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manejar asuntos financieros (cobrar la pensión, pagar la renta o los impuestos, tratar con el banco)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manejar dinero para la compra (cuánto dinero dar, calcular el cambio)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manejar otros problemas aritméticos cotidianos (tiempo entre visitas de parientes, cuánta comida comprar y preparar, especialmente si hay invitados)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Cree que su inteligencia (en general) ha cambiado en algo durante los últimos 10 años?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PUNTUACIÓN TOTAL
PHQ-9 Patient Depression Questionnaire

For initial diagnosis:
1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 √s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 √s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 √s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:
1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up √s by column. For every √: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9
For every √ Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

---

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A2662B 10-04-2005
CUESTIONARIO DE SALUD DEL PACIENTE (PHQ-9) + 3

Nombre del Paciente: _________________________ Fecha De Nacimiento: ______________ Fecha: ______________

¿En las últimas dos semanas, con qué frecuencia ha experimentado los siguientes síntomas?

<table>
<thead>
<tr>
<th>PREGUNTAS</th>
<th>Nunca</th>
<th>Varios días</th>
<th>Más de la mitad de los días</th>
<th>Casi todos los días</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Poco interés o placer en hacer cosas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Sentirse desanimado, deprimido o sin esperanza</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Tener problemas para dormir, mantenerse dormido o dormir demasiado</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Sentirse cansado o tener poca energía</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Poco apetito o comiendo demasiado</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. Sentir falta de amor propio o pensar que es un fracaso o fallarle a usted mismo o a su familia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. Tener dificultad en concentrarse en cosas tales como leer el periódico o ver televisión</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8. El moverse o hablar tan despacio que otras personas a su alrededor se dan cuenta; o todo lo contrario, que cuando está nervioso/a o inquieto/a usted se mueve muchísimo más de lo normal.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9. Pensamientos de que pudiera estar mejor muerto o hacerse daño a sí mismo. (Si contestó afirmativamente, complete la Evaluación de Riesgo de Suicidio)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

PHQ-9 Scoring Formula

<table>
<thead>
<tr>
<th># Symptoms</th>
<th>X 0</th>
<th>X 1</th>
<th>X 2</th>
<th>X 3</th>
<th>Per Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PHQ-9 Total Score: __________

10. Si contestó afirmativamente a cualquiera de los problemas en el cuestionario, ¿cuánta dificultad le han causado estos problemas en el trabajo, al atender su hogar o llevarse bien con otras personas?

☐ Ninguna Dificultad ☐ Alguna Dificultad ☐ Mucha Dificultad ☐ Muchísima Dificultad

11. ¿En los últimos dos años, se ha sentido depresivo/a o triste la mayoría de los días, a pesar de sentirse bien en otras ocasiones?

☐ Sí ☐ No

12. ¿Ha habido un período, de al menos cuatro días, en los que se sentía tan feliz, con demasiada energía o tan irritable que se metió en problemas, o su familia o amigos se preocuparon o el médico le dijo que se encontraba en un estado maníaco?

☐ Sí ☐ No

Número de Teléfono: ________________ ¿Se puede dejar mensaje? Sí o NO Nota: _______________________

Medication: __________________     Dose: ______________________     Frequency: _______________

 TOTAL SCORE __________

Geriatric Depression Scale (short form)

Instructions: Circle the answer that best describes how you felt over the past week.

1. Are you basically satisfied with your life? yes no
2. Have you dropped many of your activities and interests? yes no
3. Do you feel that your life is empty? yes no
4. Do you often get bored? yes no
5. Are you in good spirits most of the time? yes no
6. Are you afraid that something bad is going to happen to you? yes no
7. Do you feel happy most of the time? yes no
8. Do you often feel helpless? yes no
9. Do you prefer to stay at home, rather than going out and doing things? yes no
10. Do you feel that you have more problems with memory than most? yes no
11. Do you think it is wonderful to be alive now? yes no
12. Do you feel worthless the way you are now? yes no
13. Do you feel full of energy? yes no
14. Do you feel that your situation is hopeless? yes no
15. Do you think that most people are better off than you are? yes no

Total Score __________

Tools

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Common scales used in the assessment of BPSD (Adapted from Tampi et al. (2011)\(^1\))

<table>
<thead>
<tr>
<th>SCALE</th>
<th>TIME FOR COMPLETION (MINUTES)</th>
<th>SCORE RANGE</th>
<th>HIGHER SCORE MEANS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL ASSESSMENT SCALES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Pathology in Alzheimer’s Disease Rating Scale</td>
<td>20</td>
<td>0-75</td>
<td>Greater severity of behavioral symptoms</td>
</tr>
<tr>
<td>Columbia University Scale for Psychopathology in Alzheimer’s Disease (CUSP AD)</td>
<td>25</td>
<td>0-51</td>
<td>Greater severity of behavioral symptoms</td>
</tr>
<tr>
<td>Consortium to Establish a Registry for Alzheimer’s Disease Behavior Rating Scale for Dementia (CERAD-BRSD)</td>
<td>30</td>
<td>0-148</td>
<td>Greater severity of behavioral symptoms</td>
</tr>
<tr>
<td>Neuropsychiatric Inventory</td>
<td>20</td>
<td>1-144</td>
<td>Greater severity of behavioral symptoms</td>
</tr>
<tr>
<td><strong>SPECIFIC ASSESSMENT SCALES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apathy Inventory (Clinician Version)</td>
<td>5</td>
<td>0-12</td>
<td>Greater apathy</td>
</tr>
<tr>
<td>Cohen-Mansfiled Agitation Inventory (CMAI)</td>
<td>15</td>
<td>29-203</td>
<td>Greater severity of behavioral symptoms</td>
</tr>
<tr>
<td>Cornell Scale for Depression in Dementia</td>
<td>30</td>
<td>0-38</td>
<td>Greater severity of depression</td>
</tr>
</tbody>
</table>

Prefering for Your Doctor’s Visit

Fill out the information below to the best of your ability. Share it with your doctor. Be open and honest in answering any questions your doctor may ask you about the changes you’ve been experiencing. It is recommended to bring someone with you, either a family member of someone who knows you well enough to contribute information and can take notes so you don’t have to worry about remembering anything.

Has your health, memory or mood changed?

How did it change?

When did you first notice the change?

How often does it happen?

When does it happen? Is it always at a certain time of day?

What do you do when it happens?

What behaviors are the same?

Do you have problems with any of the following?

Please check the answer.

Repeating or asking the same thing over and over?

- [ ] Not at all  - [ ] Sometimes  - [ ] Frequently  - [ ] Does not apply

Remembering appointments, family occasions, holidays?

- [ ] Not at all  - [ ] Sometimes  - [ ] Frequently  - [ ] Does not apply

Writing checks, paying bills, balancing the checkbook?

- [ ] Not at all  - [ ] Sometimes  - [ ] Frequently  - [ ] Does not apply

Shopping independently (e.g., for clothing or groceries)?

- [ ] Not at all  - [ ] Sometimes  - [ ] Frequently  - [ ] Does not apply
Information and Resources for Caregivers

### Medications and medical history

List of medications (dosage, frequency) including over-the-counter and prescription: (Bring all over-the-counter and prescription medications with you to your visit.)

<table>
<thead>
<tr>
<th>List vitamins and herbal supplements:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

List current medical conditions:

<table>
<thead>
<tr>
<th>What to bring with you to your doctor visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bring someone with you, either a family member or someone who knows you well enough to contribute information and can take notes so you don’t have to worry about remembering everything. Bring all over-the-counter and prescription medications. Bring your Advance Directives if you have them.</td>
</tr>
</tbody>
</table>

Questions to ask the doctor

What are tests I need to take and how long will it take to get a diagnosis? Will you refer me to a specialist?

Could the medicines I’m taking be causing my symptoms?

Do I have any other conditions that could be causing my symptoms or making them worse?

What should I expect if it is Alzheimer’s?

Which treatments are available for Alzheimer’s? What are the risks and benefits and possible side effects?

What about participating in a clinical trial? What are the risks and benefits?

Is there anything else I should know?

When should I come back for another visit?

Where can I get information about Advance Directives if I don’t have one yet?

This tool was amended from tools developed by the Alzheimer’s Association. Some information in this tool was developed for the Chronic Care Networks for Alzheimer’s Disease (CCN/AD) project and is the joint property of the Alzheimer’s Association and the National Chronic Care Consortium.

### Information and Resource Lines

- **211:** County-wide info/resources, [http://211sandiego.org](http://211sandiego.org)
- **Aging & Independence Services:** (800) 510-2020, specific info/resources for older adults, including Adult Protective Services, [http://sandiegocounty.gov/hhsa/programs/aid/](http://sandiegocounty.gov/hhsa/programs/aid/)
- **Alzheimer’s Association:** (800) 272-3900, Alzheimer’s disease specific [http://inforesources.alz.org](http://inforesources.alz.org)
- **Alzheimer’s San Diego:** (858) 492-4400, San Diego based resource organization; [http://alzsd.org](http://alzsd.org)
- **Southern Caregiver Resource Center:** (800) 827-1008, Caregiver focused information and resources [http://caregivercenter.org/](http://caregivercenter.org/)
- **Alzheimer’s-Specific Resources**
  - **Alzheimer’s Association:** (800) 272-3900, Includes information on specific behavioral issues
  - **Alzheimer’s San Diego:** (858) 492-4400, [http://alzsd.org](http://alzsd.org)
  - **Glenner Center:** (619) 543-4700, [http://glenner.org](http://glenner.org)
  - **Southern Caregiver Resource Center:** (800) 827-1008, [http://caregivercenter.org](http://caregivercenter.org/)
  - **UC San Diego Shiley-Marcos Alzheimer’s Disease Research Center:** (858) 822-4800, [http://adrc.ucsd.edu](http://adrc.ucsd.edu)

### Common Needs Resources

- **California Department of Aging:** 916-322-5290, [http://www.aging.ca.gov](http://www.aging.ca.gov)
- **Caregiver Resources:** Southern Caregiver Resource Center, (800) 827-1008, [http://caregivercenter.org](http://caregivercenter.org)
- **Health Insurance Resources:** Health, Information, Counseling & Advocacy Program (HICAP), (858) 565-1302, [http://www.cahelthadvocates.org](http://www.cahelthadvocates.org)
- **In-Home Care Resources:** In-Home Supportive Services, (800) 510-2020, [http://sandiegocounty.gov/hhsa/programs/aid/](http://sandiegocounty.gov/hhsa/programs/aid/)
- **Jewish Family Services Older Adult Helpline** (858) 637-3040, [http://www.jfsd.org](http://www.jfsd.org)
- **Legal Resources:** Elder Law & Advocacy, (858) 565-1392, [http://www.seniorlaw-sd.org](http://www.seniorlaw-sd.org)
- **SeniorHelp.org** Directory for assisted living communities, in-home caregivers, etc. (866) 333-5183
- **US Department of Health and Human Services Administration on Aging** [http://www.aoa.gov](http://www.aoa.gov)
- **VA San Diego Healthcare System Caregiver Support** [www.caregiver.va.gov](http://www.caregiver.va.gov) (819) 497-8424
- **Mace, N. & Rabins, P** The 36-Hour Day: A Family Guide to Caring for People with Alzheimer’s Disease, other Dementias, and Memory Loss in Later Life.

### Conversation Project


### Safety Resources

- Alzheimer’s Association “Safe Return” program using identification products such as necklaces and bracelets, wallet cards, clothing labels with toll free 800 numbers on them [www.alz.org/SafeReturn](http://www.alz.org/SafeReturn)
- **Adult Protective Services:** (800) 510-2020, for elder and disabled adult abuse reporting
- **SD County Sheriff’s “Take Me Home” Program and You Are Not Alone Program** [www.sdsheriff.net/tmh](http://www.sdsheriff.net/tmh) (info on registering)
Effective Communication with Individual with Cognitive Issues

Tips for improved communications:
• Make just one request at a time.
• Speak slowly with good diction.
• Allow time for the individual to respond to your question or request.
• Use many of the five senses with the individual: sight, smell, touch, taste, sound.
• Maintain eye contact.
• Assume a comfortable, relaxed posture to make the individual at ease.
• Identify and reflect the individual’s concerns, “I see you are uncomfortable…”
• Use simple, direct statements or requests.

Using Redirection to Improve Communications
Redirection is an intention method of refocusing the individual to remain calm, cooperative, content and safe. Often, individuals with cognitive issues may be frustrated or agitated due to their inability to effectively communicate or have their needs met. It is key to enter the individual’s reality, approach in a calm manner, and communicate your desire to help.
• Present options: “Would you like this or this?”
• Compliment: “My that’s a beautiful sweater!”
• Request Help: “Can you please help me fold these towels?”
• Helpful Distractions: Food, drink, reminiscent stories, music, humor
• Validate: “You look worried.”
• Distract: “Let’s look over there…” “Let’s plan to do that later. In the meantime, …”
• Redirect: “That coffee smells good. Do you want a cup?”

Common Delusions in Individuals with Dementia
• Accusations of infidelity,
• Persons or images from TV are real,
• Fear of abandonment,
• Accusations of theft of one’s property,
• Claims of impersonation (spouse is imposter),
• Current residence is not one’s home,
• Misidentification of familiar persons.
The members of the Alzheimer’s Project Clinical Roundtable wish to acknowledge, first and foremost, the members of the San Diego County Board of Supervisors who, in May 2014, unanimously voted to launch the Alzheimer’s Project. The five-year plan’s goals include raising research funds to enhance drug development, implementing standardized guidelines for physicians to diagnose and treat patients, providing support to family and professional caregivers, and increasing the knowledge and understanding of the disease throughout the community.

The Alzheimer’s Project is an ambitious and nationally unique effort, and has placed our County at the vanguard of the fight against this global problem. Alzheimer’s disease and related dementias currently impacts the lives of 150,000 family members who are caring for the region’s approximately 60,000 individuals living with Alzheimer’s and related dementias and is the number three cause of death in our County.

The Clinical Roundtable would not have been able to accomplish the development and adoption of countywide standards of care without the dedication of many clinical practitioners and care community members affiliated with various health systems in San Diego County. We would like to thank the leadership of our respective organizations for their support as we have diverted time and energy to this effort.

https://championsforhealth.org/alzheimers