Dementia Friendly America™

EMR Decision Support Tools for Alzheimer's and Related Dementias

1. Screening Tool

Criteria For When to Use:
As a general cognitive screening tool or as part of an annual exam (Medicare Annual Wellness Visit).

How to Use:
This is the first Decision Support Tool (DST) of three that helps guide you through evidence-based assessment and care for your patients with cognitive impairment. The second is a guide to evaluation for memory loss / dementia, and the third DST is designated for the post-diagnostic follow-up visit.

Evidence Based Practice Resources:
American Academy of Neurology:
www.aan.com/Guidelines/Home/ByTopic?topicId=15

ACT on Alzheimer's Clinical Provider Practice Tool:
www.dfamerica.org

Screening Tool:
Conduct brief objective cognitive screen with the Mini-Cog (www.mini-cog.com). If score is < 4* or patient/ family express concern regarding deteriorating cognitive function, proceed with workup for possible cognitive disorder/dementia.

*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.

Contents:

References

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Nasreddine ZS, Phillips NA, Bedirian V, et al. The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild

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Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.

1.1 - Documentation

☐ **Progress Note: Screen abnormal (Mini-Cog < 4*), schedule follow-up**
Patient screened today for cognitive changes characterized by *** (e.g., forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine, etc.). Evaluation with the Mini-Cog yielded an abnormal score of ***/5. A follow-up evaluation is indicated to assess for possible cognitive disorder/dementia. Patient will return in *** weeks to complete work-up.

☐ **Progress Note: Screen normal (Mini-Cog 4-5*), schedule follow-up**
Patient screened today for cognitive changes characterized by *** (e.g., forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine, etc.). Evaluation with the Mini-Cog yielded a normal score of ***/5. However, patient/family express concern regarding deteriorating cognition and it appears that follow-up is warranted. Patient will return in *** weeks to complete cognitive disorder/dementia work-up.

☐ **Progress Note: Screen normal (Mini-Cog 4-5*), no follow-up**
Patient completed cognitive screening today with the Mini-Cog and obtained a normal score of ***/5. Routine screening will be conducted again during the next annual wellness visit.

☐ **Create your own note**

1.2 - Orders

If proceeding with a work-up, diagnostics can be ordered now or at the time of follow-up.

Labs
All of the following should be obtained in any memory loss evaluation based on American Academy of Neurology (AAN) recommendations. Repeat labs unnecessary if prior results obtained following onset of presenting memory loss.

Routine Dementia Screening Labs:
☐ BASIC METABOLIC PANEL
☐ CBC (HEMOGRAM/PLTS)
☐ LIVER PANEL (HEPATIC FUNCTION PANEL)
☐ B12 ONLY
☐ TSH, SENSITIVE

Contingent Labs (per patient history):
☐ RPR (SYPHILIS SCREEN) – The American Academy of Neurology (AAN) does not recommend routine screening for syphilis in dementia except in specific populations where the disease may be suspected.
☐ HEAVY METALS
☐ LYME TITER
☐ HIV

1.3 - Imaging

According to the American Academy of Neurology (AAN), either a Head CT or Brain MRI are considered appropriate imaging tools in evaluating memory loss.

Repeat imaging unnecessary if prior head CT or brain MRI obtained following onset of presenting memory loss. Consider MRI in cases where patient has focal neurological findings, rapidly progressive dementia, atypical presentation for Alzheimer's disease, and early onset dementia at age < 65.

- ☐ CT HEAD WITHOUT CONTRAST
- ☐ MR BRAIN/STEM WITH/WITHOUT CONTRAST

1.4 - Specialty Consult

Indication: diagnostic uncertainty, early onset dementia, atypical dementia, dementia medication management, management of moderate-severe dementia with psychosocial factors or management of behavioral symptoms of dementia

- ☐ MEMORY SPECIALTY CENTER / DIAGNOSTIC CENTER
- ☐ NEUROLOGY CONSULT-ADULTS

- ☐ NEUROPSYCHOLOGY CONSULT-ADULTS — Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Testing is typically maximally beneficial in the following score ranges: SLUMS = 18-27, MoCA = 19-27, Kokmen STMS = 19-33, MMSE/MMSE-2 = 18-28

- ☐ PSYCHIATRY CONSULT-ADULTS
- ☐ OCCUPATIONAL THERAPY (cognitive, functional eval)
- ☐ MEDICATION REVIEW (e.g., PharmD Consult)
- ☐ SLEEP STUDY / SLEEP MEDICINE
- ☐ HEALTH CARE HOME REFERRAL
- ☐ COMPLEX CARE MANAGEMENT REFERRAL

1.5 - Patient Instructions

- ☐ Patient instructions for coping with memory loss / brain health / healthy aging.

- ☐ Please bring all over the counter and prescription medications to the next appointment.

- ☐ Please bring a family member or friend (care partner) to the next appointment.

2. Diagnostic Tool

Criteria For When to Use:
During the initial work-up for patients with new onset memory loss OR following abnormal performance on cognitive screening (e.g., Mini-Cog score < 4).

An Initial Evaluation Includes:
- A thorough history addressing memory loss and cognitive dysfunction
- Objective cognitive screening / assessment
- Dementia-related laboratory studies
- Neuroimaging

How to Use:
This is the second Decision Smart Tool (DST) in a set of three that helps guide you through evidence-based assessment and care for your patients with cognitive impairment. The first is a guide to cognitive screening and the third DST is designated for the post-diagnostic follow-up visit.

Evidence Based Practice Resources:
American Academy of Neurology:
www.aan.com/Guidelines/Home/ByTopic?topicId=15

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NOTE: Consider distributing a release of information form (ROI) to all family members during the rooming process.

Contents:

2.1 - History

Select from the tools below:

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

Functional Assessment Staging of Alzheimer's Disease (FAST):
http://geriatrics.uthscsa.edu/tools/FAST.pdf

Instrumental Activities of Daily Living (IADL):
http://consultgeri.org/try-this/dementia/issue-d13.pdf

Activities of Daily Living (ADL):
http://consultgeri.org/try-this/general-assessment/issue-2.pdf

High Yield Clinical Questions:
www.alz.org/documents/mndak/high_yield_clinical_questions_for_history.pdf

2.2 - Cognitive Screening

Montreal Cognitive Assessment
The Montreal Cognitive Assessment (MoCA) is preferred as a cognitive screen over the MMSE, offering a more extensive evaluation with sensitivity of 90% for mild cognitive impairment (vs MMSE 18%) and 100% for dementia (vs MMSE 78%). Estimated administration time is 15 minutes.

Conduct MoCA (www.mocatest.org):
- MoCA is available in 30+ languages
- Instructions for administering MoCA
- 30 points is the maximum score
- Abnormal score is less than 26

St. Louis University Mental Status Exam
The St. Louis University Mental Status Exam (SLUMS) is preferred as a cognitive screen over the MMSE, offering a more reliable evaluation with sensitivity of 92% for mild cognitive impairment (vs MMSE 18%) and 100% for dementia (vs MMSE 78%). Estimated administration time is 10 minutes.

Conduct SLUMS (http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf):
- Instructions for administering SLUMS (www.elderguru.com/downloads/SLUMS_instructions.pdf)
- 30 points is the maximum score
- Abnormal score is less than 27 (HS education) or less than 25 (< HS)

2.3 - Documentation/HPI

☐ **Progress Note: Cognitive Impairment Workup**
Patient evaluated today for cognitive changes characterized by *** (e.g., Mini-Cog score < 4, forgetfulness, repeating self, misplacing things, confusion, inability to carry out daily routine, etc.). Evaluation with the *** (e.g., MoCA/SLUMS) yielded a score of ***/30. Will review current medication list and order routine dementia labs and neuroimaging to rule out common medical causes of cognitive impairment. A follow-up visit will be scheduled for *** weeks to review diagnosis and discuss treatment recommendations.

☐ **Create your own note**

2.4 - Orders

If proceeding with a work-up, diagnostics can be ordered now or at the time of follow-up.

Labs
All of the following should be obtained in any memory loss evaluation based on American Academy of Neurology (AAN) recommendations. Repeat labs unnecessary if prior results obtained following onset of presenting memory loss.

Routine Dementia Screening Labs:
☐ BASIC METABOLIC PANEL
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Contingent Labs (per patient history):
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☐ CT HEAD WITHOUT CONTRAST
☐ MR BRAIN/STEM WITH/WITHOUT CONTRAST

2.6 - Specialty Consult

Indication: diagnostic uncertainty, early onset dementia, atypical dementia, dementia medication management, management of moderate-severe dementia with psychosocial factors or management of behavioral symptoms of dementia

- ☐ MEMORY SPECIALTY CENTER / DIAGNOSTIC CENTER
- ☐ NEUROLOGY CONSULT-ADULTS

- ☐ NEUROPSYCHOLOGY CONSULT-ADULTS — Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Testing is typically maximally beneficial in the following score ranges: SLUMS = 18-27, MoCA = 19-27, Kokmen STMS = 19-33, MMSE/MMSE-2 = 18-28

- ☐ PSYCHIATRY CONSULT-ADULTS
- ☐ OCCUPATIONAL THERAPY (cognitive, functional eval)
- ☐ MEDICATION REVIEW (e.g., PharmD Consult)
- ☐ SLEEP STUDY / SLEEP MEDICINE
- ☐ HEALTH CARE HOME REFERRAL
- ☐ COMPLEX CARE MANAGEMENT REFERRAL

2.7 - Diagnosis*

Working Diagnosis

- ☐ **Memory loss (780.93)**
  Patients presenting with memory loss who have not completed an evaluation to enable a diagnosis can be classified as having "memory loss."

- ☐ **Mild cognitive impairment (MCI) (331.83)**
  Mild deficits in 1 (or more) cognitive function(s): memory, executive, visuospatial, language, attention, intact ADLs and IADLs; does not meet criteria for dementia

- ☐ **Unspecified dementia without behavioral disturbance (294.20)**
  Cause of dementia is unknown. No behavioral symptoms are present.

- ☐ **Unspecified dementia with behavioral disturbance (294.21)**
  Cause of dementia is unknown. Behavioral symptoms are present.

- ☐ **Delirium (780.09)**
  Acute onset confusion and fluctuating consciousness/alertness. Markedly reduced responsiveness to environmental stimuli. Presence of dementia unknown.

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

2.8 - Patient Instructions

- ☐ Patient instructions for coping with memory loss / brain health / healthy aging.
- ☐ Please bring a family member or friend (care partner) to the next appointment.
- ☐ Contact the Eldercare Locator at www.eldercare.gov or call 1-800-677-1116 to get connected to aging services such as financial assistance, home delivered meals, transportation, adult day services and long-term care options in every community across the US.

3. Treatment/Management Tool

Criteria For When to Use:
During the follow-up visit for patients with new onset memory loss, Mini-Cog score less than 4, MoCA test score less than 26, or SLUMS less than 27 (HS education) or less than 25 (less than HS education).

How to Use:
This is the third Decision Support Tool (DST) of three that helps guide you through evidence-based care for your patients with memory loss / dementia. The first is a guide to cognitive screening and the second DST is designated for the initial evaluation visit.

Evidence Based Practice Resources:
American Academy of Neurology:
www.aan.com/Guidelines/Home/ByTopic?topicId=15

ACT on Alzheimer's Clinical Provider Practice Tool &
ACT on Alzheimer's Managing Dementia Across the Continuum:
www.dfamerica.org

NOTE: Consider distributing a release of information form (ROI) to all family members during the rooming process.

Content:

3.1 - Documentation

☐ **Progress Note: Follow-up Memory Loss/Dementia**
Patient seen today in follow-up for symptoms of memory loss/cognitive impairment. A recent work-up included *** (e.g., labs, neuroimaging, cognitive/functional testing). Neurological exam was *** (e.g., nonfocal; suggestive of parkinsonism; notable for abnormal cognitive screening with the MoCA). The broader work-up was remarkable for *** (e.g., cerebral atrophy; small vessel ischemic disease; vitamin B12 deficiency). My impression is the patient is suffering from *** (e.g., Alzheimer's disease, Lewy Body dementia). We discussed treatment options today and the patient is agreeable to *** (e.g., starting Aricept 5mg qd). His/her care partner has been identified as *** (e.g., name of spouse, adult child, close friend) and will plan to accompany the patient to all medical appointments. For disease education and support, I have referred the patient/family to ***(e.g., Alzheimer's Association; local support group; care coordination). A follow-up appointment will be made in *** weeks to monitor progress.

☐ **Create your own note**

3.2 - Diagnosis*

☐ **Mild cognitive impairment (MCI) (331.83)**
- Mild deficits in 1 (or more) cognitive function(s): memory, executive, visuospatial, language, attention
- Intact ADLs and IADLs
- Does not meet criteria for dementia

☐ **Alzheimer's disease (331.0)**
- Most common type of dementia (60%-80% of cases)
- Memory loss, confusion, disorientation, dysnomia, impaired judgment/behavior, apathy, depression

☐ **Dementia with Lewy bodies (331.82)**
- Second most common type of dementia
- Hallmark symptoms include visual hallucinations, parkinsonism and fluctuations in cognition

☐ **Frontotemporal dementia (331.19)**
- Third most common type of dementia affecting individuals in their 50s and 60s
- EITHER marked changes in behavior/personality OR language (difficulty with speech production or word meaning) with relative sparing of episodic memory

☐ **Vascular dementia (290.40)**
- Relatively rare in pure form (6%-10% of cases)
- Symptoms often overlap with AD: there is sparing of recognition memory

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

3.2 - Diagnosis (cont.)

Other:

- [ ] Delirium (780.09)
  - Refer to Delirium protocol
- [ ] Normal pressure hydrocephalus (331.5)
- [ ] Primary progressive aphasia (784.3)
- [ ] Corticobasal degeneration (331.6)
- [ ] Posterior cortical atrophy (331.9)
- [ ] CJD (Creutzfeldt-Jakob disease) (046.19)
- [ ] Unspecified dementia without behavioral disturbance (294.20)
- [ ] Unspecified dementia with behavioral disturbance (294.21)
- [ ] Memory loss (780.93)

3.3 - Coordination of Care

- [ ] Complete or update Health Care Directive and Financial Surrogacy documents.
- [ ] Care coordination referral.
- [ ] Instructions for check-out staff: Patient to fill out ROI for care partner.
- [ ] Instructions for check-out staff: Enter care partner name and contact information into
- [ ] EMR patient demographics.

3.4 - End of Life Planning

- [ ] Discuss role of palliative care and hospice.
- [ ] Complete POLST.

3.5 - Report Suspected Abuse

- [ ] Report suspected abuse, neglect (including self-neglect), or financial exploitation.

3.6 - Consults/Referrals

Indication: diagnostic uncertainty, early onset dementia, atypical dementia, dementia medication management, management of moderate-severe dementia with psychosocial factors or management of behavioral symptoms of dementia.

- ☐ MEMORY SPECIALTY CENTER / DIAGNOSTIC CENTER
- ☐ NEUROLOGY CONSULT-ADULTS

- ☐ NEUROPSYCHOLOGY CONSULT-ADULTS — Neuropsychological evaluation is typically most helpful for differential diagnosis, determining nature and severity of cognitive functioning, and the development of an appropriate treatment plan. Testing is typically maximally beneficial in the following score ranges: SLUMS = 18-27, MoCA = 19-27, Kokmen STMS = 19-33,
  MMSE/MMSE-2 = 18-28.

Indication: Safety/Driving

A formal driving evaluation is recommended for newly diagnosed dementia patients who drive.

- ☐ OCCUPATIONAL THERAPY DRIVING EVALUTION
- ☐ OCCUPATIONAL THERAPY – Home Safety and Medication Compliance (e.g., medication management, home safety evaluation)
- ☐ OCCUPATIONAL THERAPY / PHYSICAL THERAPY – Fall risk assessment, maximize function

Patient and Care Partner Instructions:
Read "At the Crossroads: Family Conversations about Alzheimer's & Driving"
http://www.thehartford.com/mature-market-excellence/publications-on-aging

Visit Alzheimer's Association Dementia & Driving Resource Center
http://www.alz.org/care/alzheimers-dementia-and-driving.asp

Indication: Polypharmacy Contributing to Cognitive Disorder

- ☐ MEDICATION REVIEW (e.g., PharmD, MTM Consult)

Indication: Counseling, Education and Support Systems

- ☐ COMPLEX CARE MANAGEMENT REFERRAL
- ☐ HEALTH CARE HOME REFERRAL

Patient and Care Partner Instructions:
For disease education, counseling support and dementia-specific resources, contact:
Alzheimer's Association 24/7 Helpline – Call 800-272-3900 or visit www.alz.org
Eldercare Locator – Call 1-800-677-1116 or visit www.eldercare.gov

Indication: Cognitive Stimulation, Rehabilitation, and Healthy Lifestyle

Patient and Care Partner Instructions:
Read the "Living Well Workbook":
www.alz.org/mnnd/documents/15_ALZ_Living_Well_Workbook_Web.pdf

Indication: Newly Diagnosed Dementia Resulting in Difficulty Coping with Diagnosis For Both Patient and Care Partners

3.6 - Consults/Referrals (cont.)

☐ REFERRAL TO BEHAVIORAL HEALTH

Indication: Behavioral Interventions
Each link opens patient education handouts provided by the Alzheimer's Association. The handouts can be printed and given to the patient or care partner.

Screening, Identifying and Managing Behavioral Symptoms in Patients With Dementia:
www.actonalz.org/pdf/Figure1.pdf

Potential Nonpharmacologic Strategies:
www.actonalz.org/pdf/Table1.pdf

General Nonpharmacologic Strategies:
www.actonalz.org/pdf/Table2.pdf

Behaviors:
www.alz.org/national/documents/brochure_behaviors.pdf

Communication:
www.alz.org/national/documents/brochure_communication.pdf

Agitation:
www.alz.org/documents/mndak/emr_agitation_link.pdf
Tips to Minimize Unwanted Actions in Persons with Dementia:
www.alz.org/documents/mndak/emr_unwanted_actions_link.pdf

Communicating Using a Therapeutic Response/Emotional Truth:
www.alz.org/documents/mndak/emr_therapeutic_response_link.pdf

Indication: Behavioral Interventions (cont.)
☐ REFERRAL TO BEHAVIORAL HEALTH
☐ REFERRAL TO GERIATRIC PSYCHIATRY

Indication: Sleep Disturbance
☐ REFERRAL FOR SLEEP STUDY / SLEEP MEDICINE

3.7 - Medication Treatment

Patients with mild cognitive impairment or dementia should be followed every 1-3 months in the setting of newly initiated medications. Patients with stable symptoms and medication dosing may be followed at 6 month to 1 year intervals at which time cognitive, behavioral and functional status should be reassessed.

Contraindicated Medications:
The use of anticholinergics (e.g., diphenhydramine, oxybutynin, Tylenol PM), benzodiazepines (e.g., lorazepam, alprazolam, zoldipem), mood stabilizers (e.g., valproic acid), and narcotics (e.g., oxycontin, methadone, morphine) should be avoided in dementia.

Indication: Mild-Moderate Alzheimer's Disease
- Alzheimer's Medications (description): Medications in Alzheimer's disease provide symptomatic benefit, but do not impact disease course.
- Cholinesterase Inhibitors: Decrease to maximally tolerated dose if patient experiences cholinesterase-related side effects of GI intolerance, insomnia, weight loss, dizziness, etc.
- Consider baseline EKG in patient with history of bradyarrhythmia as these medications may result in sinus arrhythmia or AV block.

☐ donepezil (ARICEPT) 10 MG tablet (5 mg for one month, increase to 10 mg after first month)
☐ galantamine (RAZADYNE) 8 MG tablet (8 mg for one month, increase to 16 mg after first month)

- Suggest using Rivastigmine (EXELON) patch in instances of oral cholinesterase inhibitor intolerance. Prescribe 4.6 mg patch q24 hours x 1 month; increase to 9.5 mg after 1 month.

☐ rivastigmine (EXELON) 4.6 MG/24HR patch
☐ rivastigmine (EXELON) 9.5MG/24HR patch

☐ ECG 12-LEAD ROUTINE (EKG)

Indication: Moderate-Severe Alzheimer's Disease
- NMDA Antagonists:

☐ memantine (NAMENDA) 5 MG tablet

Indication: Depression/Anxiety

☐ sertraline (ZOLOFT) 25 MG tablet PO qAM x 1 week, then 50 mg qAM. May increase by 50 mg increments to maximum dose of 200mg/day as needed and if tolerated
☐ escitalopram oxalate (LEXAPRO) 10 MG tablet (for Depression with Predominant Anxiety Component)
☐ mirtazapine (REMERON) 15 MG PO qhs. May increase by 15 mg increments to maximum dose of 45 mg PO qhs if needed and tolderated

Indication: Insomnia

☐ trazodone (DESYREL) 50 MG tablet (start at 25-50 mg, increase to 75-100 mg within 1 month if desired effect is not obtained)

3.7 - Medication Treatment (cont.)

Indication: Agitation / Psychosis

- Neuroleptics: Recommend starting neuroleptic as PRN medications with gradual transition to standing medication if patient has continued behavioral problems. Suggest obtaining baseline EKG due to impact upon QT interval.

☐ ECG 12-LEAD ROUTINE (EKG)

- Atypical antipsychotics: Atypical antipsychotics may result in increased mortality in the elderly and have not shown to be any more effective than behavioral interventions within the geriatric population (see NEJM article). If behavioral interventions are insufficient, quetiapine and risperidone are recommended.

☐ quetiapine (SEROQUEL) 12.5 MG tablet PO qd as needed
☐ risperidone (RISPERDAL) 0.25 MG tablet PO qd as needed

3.8 - Patient Instructions

☐ Patient instructions for coping with memory loss and behavior challenges.

☐ Please bring a family member or friend (care partner) to the next appointment.

☐ Contact the Alzheimer's Association 24/7 Helpline at 1-800-272-3900 or www.alz.org for information, education and support.

☐ Contact the Eldercare Locator at www.eldercare.gov or call 1-800-677-1116 to get connected to aging services such as financial assistance, home delivered meals, transportation, adult day services and long-term care options in every community across the US.