### Supporting Clients with Memory Concerns

<table>
<thead>
<tr>
<th>When client has diagnosis:</th>
<th>When client has memory concerns, but no diagnosis:</th>
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<tbody>
<tr>
<td>• Offer care consultation or refer to the Alzheimer’s Association 24/7 Helpline for care consultation</td>
<td>• Conduct screening (see Flow Chart)</td>
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<tr>
<td>• Provide education about diagnosis and disease process</td>
<td>• Encourage client to make appointment with primary care physician for memory loss work-up</td>
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#### Identify client’s needs using organization’s assessment tool.

#### Provide or arrange supports based on client’s needs, diagnosis and stage of disease (if known).

**Counseling and Support**
- Individual and family counseling
- Person-centered care includes understanding cultural context in which people are living ([www.actonalz.org/](http://www.actonalz.org/)cultural-competency-awareness)

**Care Partner Education and Support (if client has a care partner)**
- Support groups, respite care, caregiver education and training programs, and caregiver coaching services
- Provide information on maintaining health and well-being ([visit www.alz.org/care](http://www.alz.org/care))
- Provide education on behaviors and stages ([visit www.alz.org/care](http://www.alz.org/care))

**Health, Wellness and Engagement**
- Engagement programs ([call the Alzheimer’s Association 24/7 Helpline at 1-800-272-3900](http://www.alz.org/care/dementia-medic-alert-safe-return.asp))
- Adult day
- Exercise and healthy eating programs

**Home and Personal Safety**
- Refer to an occupational therapist and/or physical therapist to address fall risk, sensory/mobility aids and home modifications
- Refer to occupational therapy for driving evaluation ([http://myaota.aota.org/driver_search/index.aspx](http://myaota.aota.org/driver_search/index.aspx))

**Medication Therapy and Management**
- Refer to health care provider to create a medication management plan
- Refer to pharmacist for medication review and to simplify medication regimen
- Educate client and care partner on medication management aids (pill organizers, dispensers, alarms)

**Legal Planning**
- Refer to an elder law attorney
- Encourage client to assign durable power of attorney and health care directive

**Advance Care Planning**
- Encourage client and family to discuss and document preferences for care ([download state specific advance directive forms at www.caringinfo.org](http://www.caringinfo.org))

**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.**

**Determine timeframe for follow-up and plan for communication.**
Provide usual services

Is person willing to be screened?

No

Provide usual services

Mini-Cog score 4-5* AND Family Questionnaire 0-2

Yes

Screen cognition using Mini-Cog and Family Questionnaire (if family available)

Mini-Cog score 0-3* OR Family Questionnaire 3 or more

Encourage client to make appointment with primary care physician for memory loss work-up

Identify client’s needs using organization’s assessment tool (person-centered care includes understanding cultural context in which people are living; see Culturally Responsive Resources at left)

Provide or arrange supports based on client’s needs, diagnosis and stage of disease (if known)

Determine timeframe for follow-up and plan for communication

Person contacts community based organization and has memory concerns

Mini-Cog
www.mini-cog.com

Mini-Cog Administration
https://www.youtube.com/watch?v=CRQEleghdb0w

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

Culturally Responsive Resources
www.actonalz.org/culturally-responsive-resources

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

The Mini-Cog is a five-point cognitive screening tool that incorporates three-word verbal recall and a clock draw. The Mini-Cog requires the person to remember three words. Immediately following the presentation of the words, the person is asked to draw the face of a clock and set the hands at 10 past 11. After they draw the clock, the person is asked to recall the three words. One point is awarded for each word recalled without assistance. The person receives two points if every number on the clock is present and evenly spaced and the hands are positioned at 11 and 2. No points are awarded if either hand is set incorrectly or if numbers are missing, duplicated, or clearly spaced unequally.

Studies have shown that the word choice may increase the sensitivity of the screening with the most sensitive word combination being “leader, season, table.” In addition, the clock draw is particularly more sensitive when staff use phrasing that is purposely abstract by instructing the person to set the time to “10 past 11” as opposed to saying “eleven ten.” For scoring purposes, the length of the hands does not matter and full credit should be awarded even when the hand pointing to the 2 is shortest (assuming accuracy with number placement).

**Mini-Cog Scoring:** 4-5*: pass; 0-3*: fail

*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.

**Mini-Cog References**


Family Questionnaire

If a family member accompanies the person, staff may want to ask for their input. The National Chronic Care Consortium and the Alzheimer’s Association’s Family Questionnaire is a tool that can be used to obtain the family member’s insight on a person’s cognitive functioning. The questionnaire asks six questions of family members who have regular contact with the person.

**Family Questionnaire Scoring:** Not at all = 0; Sometimes = 1; Frequently = 2

A score 3 or greater suggests the need for additional evaluation.

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

If the Mini-Cog or Family Questionnaire indicates that the person may have memory loss, refer the client to their primary care physician or a specialist (e.g., neurologist, geriatric psychiatrist, geriatrician) for a complete memory loss work-up.
Mild Cognitive Impairment and Stages of Alzheimer’s: Symptoms and Duration of Disease*

Alzheimer’s symptoms vary. The information below provides a general idea of how abilities change during the course of the disease. Not everyone will experience the same symptoms nor progress at the same rate.

<table>
<thead>
<tr>
<th>Mild Cognitive Impairment (MCI)</th>
<th>Alzheimer’s Disease Early Stage</th>
<th>Alzheimer’s Disease Middle Stage</th>
<th>Alzheimer’s Disease Late Stage</th>
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<tbody>
<tr>
<td>• Mild forgetfulness</td>
<td>• Increased short-term memory loss</td>
<td>• Significant short-term memory loss; long-term memory begins to decline</td>
<td>• Severe disorientation to time and place</td>
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<tr>
<td>• Increasingly overwhelmed by making decisions, planning steps to accomplish a task or interpreting instructions</td>
<td>• Difficulty keeping track of appointments</td>
<td>• Fluctuating disorientation</td>
<td>• No short-term memory</td>
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<tr>
<td>• Mild difficulty finding way in unfamiliar environments</td>
<td>• Trouble with time/sequence relationships</td>
<td>• Diminished insight</td>
<td>• Long-term memory fragments</td>
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<tr>
<td>• Mild impulsivity and/or difficulty with judgment</td>
<td>• More mental energy needed to process information</td>
<td>• Changes in appearance</td>
<td>• Loss of speech</td>
</tr>
<tr>
<td>• Family and friends notice some or all of these symptoms</td>
<td>• Trouble multi-tasking</td>
<td>• Learning new things becomes very difficult</td>
<td>• Difficulty walking</td>
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<tr>
<td>• IADLs only mildly compromised; ADLs are intact</td>
<td>• May write reminders, but lose them</td>
<td>• Restricted interest in activities</td>
<td>• Loss of bladder control</td>
</tr>
<tr>
<td></td>
<td>• Mild mood and/or personality changes</td>
<td>• Declining recognition of acquaintances, relatives</td>
<td>• No longer recognizes family members</td>
</tr>
<tr>
<td></td>
<td>• Increased preference for familiar things</td>
<td>• Mood and behavioral changes</td>
<td>• Inability to survive without total care</td>
</tr>
<tr>
<td></td>
<td>• IADLs more clearly impaired; ADLs slightly impaired</td>
<td>• Alterations in sleep and appetite</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Wandering</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Loss of bladder control</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• IADLs and ADLs broadly impaired</td>
<td></td>
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</table>

Resources

Mild Cognitive Impairment (MCI)
www.mayoclinic.com/health/mild-cognitive-impairment/DS00553

Stages of Alzheimer’s
www.alz.org/alzheimers_disease_stages_of_alzheimers.asp

*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.