# Detection & Diagnosis

## Persons Living with Cognitive Impairment and Families/Caregivers

- **It is normal for our brains to change as we age – however, signs of dementia including loss of memory, language, and thinking abilities, are not normal aspects of aging. Talk to your health care providers early about any concerns you might have about memory or thinking ability.** Your care team should ask you some questions about this and should set up a follow-up appointment. **If you have concerns, speak up or ask.**
- You can keep your brain healthy in many ways – see more here
- **If you've taken an online memory or cognitive test or had a memory assessment with a community based provider, discuss your results with your healthcare team.**
- **Talk to your health care providers about any concerns you have about being able to hear or see.** If you do have difficulty hearing, talk about hearing aids or an assisted listening device (e.g., pocket talker). If you have changes in vision, it's important to get this evaluated and corrected.
    - How to identify hearing loss
    - How to communicate with someone who has hearing loss
- **Review the resources developed by the Washington State Dementia Action Collaborative, especially the Dementia Road Map: A Guide for Family and Care Partners.**
    - This tool guides people living with memory loss and caregivers through action steps and questions.
- **Ask your care team about local resources**. Connect to others in your community who may be going through the same process. Some resources include are available here.

## Primary Care Clinics

- **Assess cognition when:**
  - concerns are raised by patients or family
  - patient presents after completing prior community-based assessment
  - clinical signs and symptoms (e.g., Alzheimer's Association)
  - abnormal office-based cognitive brief assessment
  - during the Medicare Annual Wellness Visit
- **Assess for and address hearing and vision loss** (e.g., readers, hearing aids, voice amplifiers) **before cognitive assessment,** as sensory impairment can increase risk for dementia and complicate diagnosis
- **Center patients and families/caregivers as part of the care team;** speak directly to the patient and obtain caregiver input when cognitive changes are suspected and strongly encourage presence at all appointments once impairment identified.
- **Ensure providers are trained to communicate dementia diagnoses through a dignified, culturally responsive approach** (see **Appendix E.** Alzheimer's Association Principles for a Dignified Diagnosis)
- **Ensure office staff, community partners, etc. understand how to communicate** with someone with memory loss through dementia communication strategies
- **Support early detection through provider and staff training,** including how to discuss uncertainty in diagnosis. Refer to the Dementia Action Collaborative for guidance.
- **Use a two-step diagnostic process:**
  - **See Dementia Action Collaborative position paper for validated assessment tools,** including those for people with low literacy
  - **Step one:** brief, validated cognitive assessment (<5 minutes) during annual wellness visit or other visit, informed by direct observation and caregiver input.
    - See Alzheimer's Association Medicare Annual Wellness Visit algorithm **Appendix D**.
  - **Step two:** if positive result, follow-up visit for further evaluation, potential diagnosis, and care planning. (**CPT 99483**)
    - Include family/caregivers in the conversation and utilize family/caregiver assessment tools.
    - Objective assessment of cognition (e.g., MoCA, RUDAS, SLUMS)
    - Evaluate for and discuss reversible causes or contributors (e.g., B12 deficiency, thyroid disease, medications such as anticholinergics, alcohol use, depression, sleep apnea, hearing or vision loss if not already done)

        - Order imaging only when clinically indicated, to rule out intracranial mass, hydrocephalus, or subdural hematoma.
- I**f diagnosis is uncertain,** repeat evaluation in 6-12 months or consider referral to a specialist
- **Diagnostic Criteria:**
    - Combination of functional assessment, objective cognitive assessment, and family/caregiver input to determine diagnosis.
- **When a diagnosis is made, discuss ways to reduce risk and improve quality of life. Consider pulling in other team members** (e.g., behavioral health specialist, social worker) to support social/behavioral aspects of care, and to answer further questions about lifestyle changes and caregiver support
    - Inquire about driving status and safety and home safety/fall risk
    - Assess for hearing and vision loss if not already done.
    - Assess for sleep quality and sleep disturbance, depression, risk of suicide, presence of firearms in the house
    - Discuss how to mitigate confusion, agitation, aggression, and/or wandering
    - Review and manage medications, and offer tools like pill boxes as appropriate
- **Assess caregiver stress, capacity, and support.**
    - Identify the primary caregiver and any other family or friends who are involved in arranging, coordinating or providing care
    - Provide support in understanding the caregiver's role and what they need to know to carry out tasks
    - Assessment should inform the care plan with measurable outcomes for the caregiver
    - Assessment is ongoing as stress, capacity, and support can fluctuate over time.
- **Connect patient and family/caregivers** to appropriate local and/or state/national sources of care and support, including explicitly for family/caregivers. See Implementation Guide here.
    - Stock and provide a copy of the Washington State Dementia Action Collaborative's **Dementia Road Map: A Guide for Family and Care Partners**
- **Do not utilize blood-based biomarker testing for those without measurable cognitive impairment**
- **Assess appropriateness of biomarker testing**
    - Blood based biomarkers (BBM) may be appropriate for those with measurable MCI or mild dementia.

- Counsel persons with memory loss and their families/caregivers about what BBM results mean
    - BBMs detect existence of Alzheimer's disease pathology – they do NOT diagnose dementia
    - Review the currently most accurate tests available
    - Explain that a positive result may increase the likelihood that Alzheimer's disease pathology is contributing to symptoms, but does not guarantee progression to dementia. Similarly, a negative result means AD is less likely but does not guarantee that you won't develop dementia later in life
    - Utilize the same principles as **Appendix E.** Alzheimer's Association Principles for a Dignified Diagnosis)

- **Discuss risks and benefits of anti-amyloid therapies as appropriate**
  - Benefits: FDA-approved for MCI or mild dementia due to Alzheimer's disease with confirmed amyloid positivity; In trials, agents slowed cognitive and functional decline by 27-35% - does not improve or stabilize.
  - Risks:
    - Amyloid-Related Imaging Abnormalities (ARIA) is a primary safety concern. ARIA rates are higher in people with APOE e4, so APOE genotyping should be discussed as part of risk stratification. Explain risks of serious complications, including death.
    - Thrombolytic therapy (e.g., IV tPA for stroke) carriers substantially higher hemorrhage risk during anti-amyloid treatment
    - Infusion related reactions occur in 8-25% of patients
  - Logistical steps:
    - Biweekly infusions with regular MRI monitoring is required
    - Discuss financial costs expected beyond co-pays (infusion center fees, clinic visits, MRI scans)
    - If not already done, ensure advance directives are in place before initiating treatment

- **Engage in continuing education opportunities** to support quality improvement in dementia care (e.g., Project ECHO)

## Residential Facilities

- Make information about brain health and cognitive aging readily available to older adults and their families/caregivers.
- Encourage older adults whose provider has recommended a diagnostic evaluation to follow through.
- Provide regular dementia-specific training for staff, including environmental and non-pharmacological interventions for neuropsychiatric symptoms.
- Educate health care providers and staff on:
    - Symptoms of hearing loss and vision loss and how to communicate with persons who have hearing loss.

## Hospitals

- Educate staff about Mild Cognitive Impairment (MCI), Alzheimer's disease and other dementias including on disease progression, care needs, communication, involving the family and other caregivers in decisions, and potential impact on hospitalization.
- Regularly educate staff the differences between dementia, delirium, and depression (3D's) See the Northwest Geriatric Workforce Enhancement Center for resources: Frontline Tools: 3D's Delirium, Dementia, & Depression - NW GWEC

<table>
<tr><th></th><th>Common Features</th><th>Hallmarks</th></tr>
<tr><td>Dementia</td><td rowspan="3">Subjective confusion<br>Difficulty performing tasks<br>"Not right" on interview<br>Loved ones are worried</td><td>Problems with memory plus with speech, actions, recognition, or executive functioning</td></tr>
<tr><td>Delirium</td><td>Trouble with attention and concentration; Rapid onset; waxing and waning; Due to medical cause</td></tr>
<tr><td>Depression</td><td>Decreased concentration and interest; Sensorium is clear</td></tr>
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## Health Plans

- Increase member awareness of how to maintain brain health across the life-course, about the difference between age-related changes in memory and the warning signs of dementia, and about the benefits of timely diagnosis of Mild Cognitive Impairment (MCI), Alzheimer's disease, and other dementias.
- Flag members who may be demonstrating a high risk for cognitive impairment (e.g., falls/fall-related claims, inconsistency in pharmacy claims, motor vehicle accidents, failure to thrive, delirium, and changes in utilization patterns)
- Explore opportunities to allow billing for cognitive assessment delivered by a trained non-physician in primary care (e.g., CPT code 96138)

## Employers

- Promote employee wellness by increasing awareness of how to maintain brain health across the life-course, about the difference between age-related changes in memory and the warning signs of dementia, and about the benefits of timely diagnosis of Mild Cognitive Impairment (MCI), Alzheimer's disease, and other dementias.

## HCA

None

## DOH

None