UC San Diego
Health Sciences

San Diego / Imperial
Geriatric
Education Center

AGE-FRIENDLY HEALTH CARE:
A FOCUS ON DEMENTIA ASSESSMENT IN OLDER ADULTS

DEVELOPED AND PRESENTED BY:
THE SAN DIEGO /IMPERIAL GERIATRIC EDUCATION CENTER (SDIGEC)

The SDIGEC is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services under grant number U1QHP28717, Geriatric Workforce Enhancement Project award.

San Diego Imperial Geriatric Education Center (SDIGEC) GWEP

The San Diego/Imperial Geriatric Education Center is one of 48 academic Geriatric Workforce Enhancement Programs funded by the Health Resources and Services Administration.

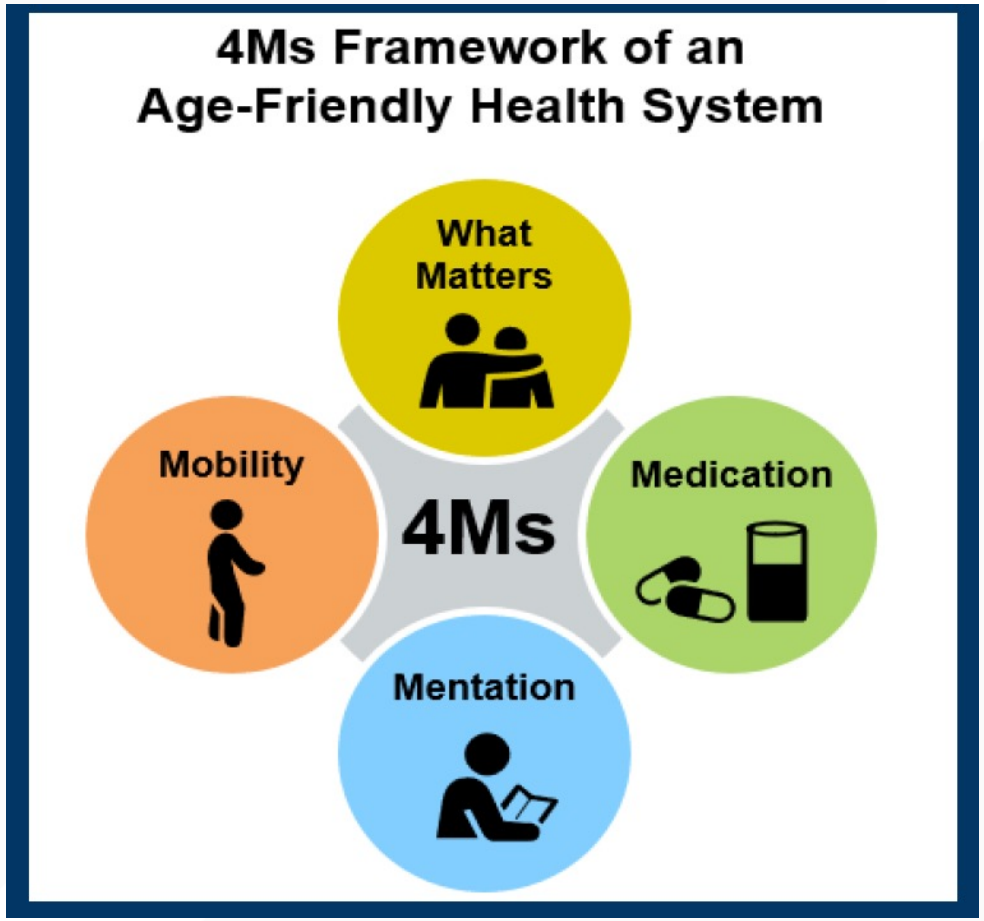
Our Center is working to address the need for enhanced geriatric education on Alzheimer's Disease and Related Dementias and Age-Friendly Healthcare in both San Diego and Imperial Counties in southern California.

SAN DIEGO / IMPERIAL
GERIATRIC
EDUCATION CENTER

https://www.sandiegoimperialgwep.com/

We train primary care providers, health profession trainees, patients, families, caregivers and direct care workers to provide value-based care and improve health outcomes for older adults.

Refresher on 4Ms of Age-Friendly Care



what Matters

Know and align care with what Matters to each older adult

Medications

Deprescribe or do not prescribe high- risk meds considering what matters most

Mobility

Promote safe mobility to maintain function and do what matters most

Mentation / Mind

Prevent, diagnosis, and manage delirium, depression, and dementia to enjoy what matters most

MENTATION (MIND)

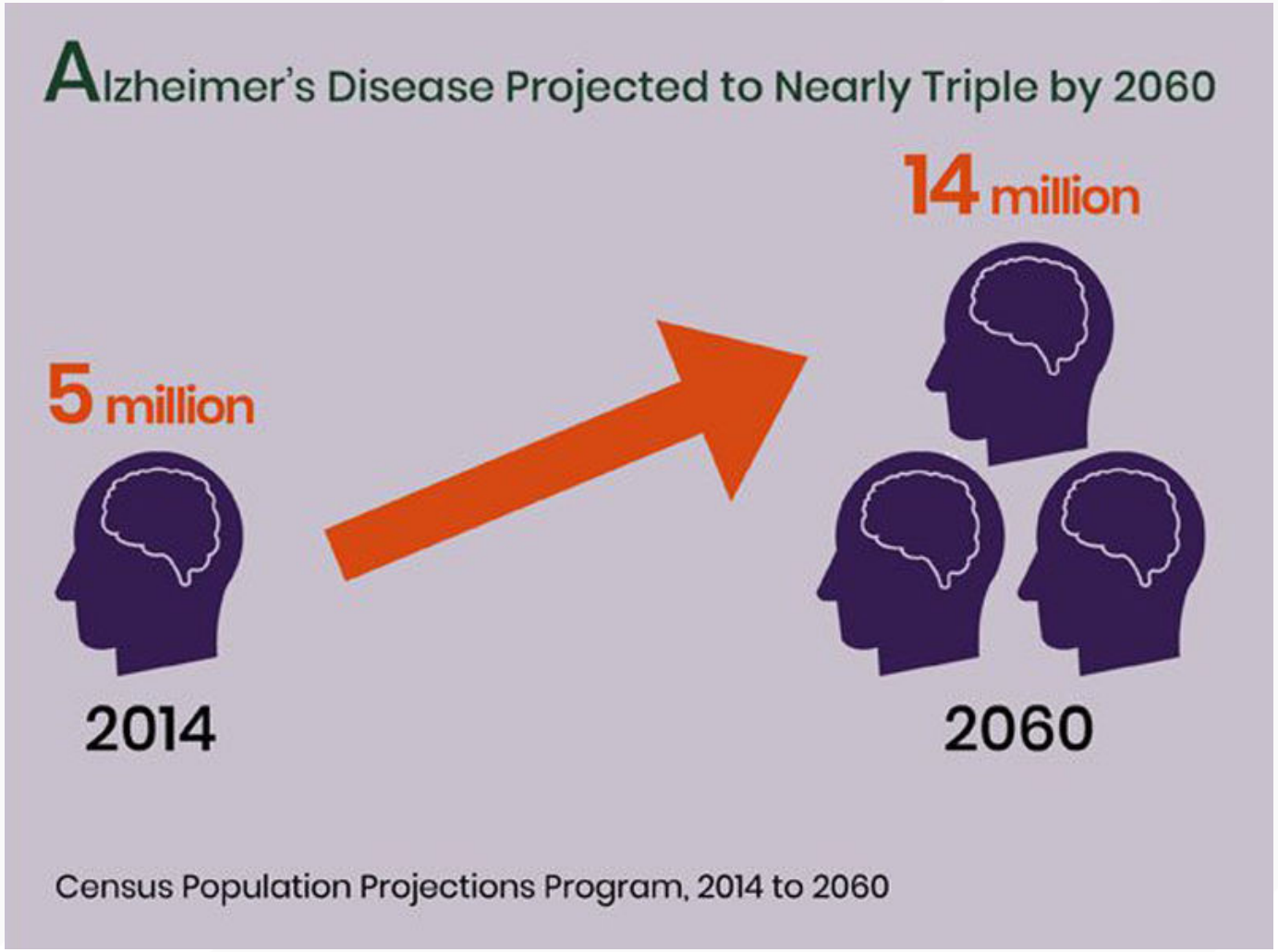
Mind

Prevent, diagnosis, and manage delirium, depression, and dementia to enjoy what matters most

Reflection:

Approximately how many of your geriatric patients have you disclosed a diagnosis of dementia to in the past month?

MENTATION (MIND)



- Dementia affects an estimated 30% of those 85 years or older
- 50% of patients with dementia are unrecognized in the primary care setting

Alzheimer's Association. 2019 Alzheimer's Disease Facts and Figures. *Alzheimer's & Dementia* (2019); 15(3):321-387
Chodosh J., Petitti D. B., Elliott M., Hays R. D., Crooks V. C., Reuben D. B., Galen Buckwalter J. and Wenger N. Physician Recognition of Cognitive Impairment: Evaluating the Need for Improvement. *Journal of the American Geriatric Society* (July 2004); 52(7):1051-1059.

San Diego County

2015:

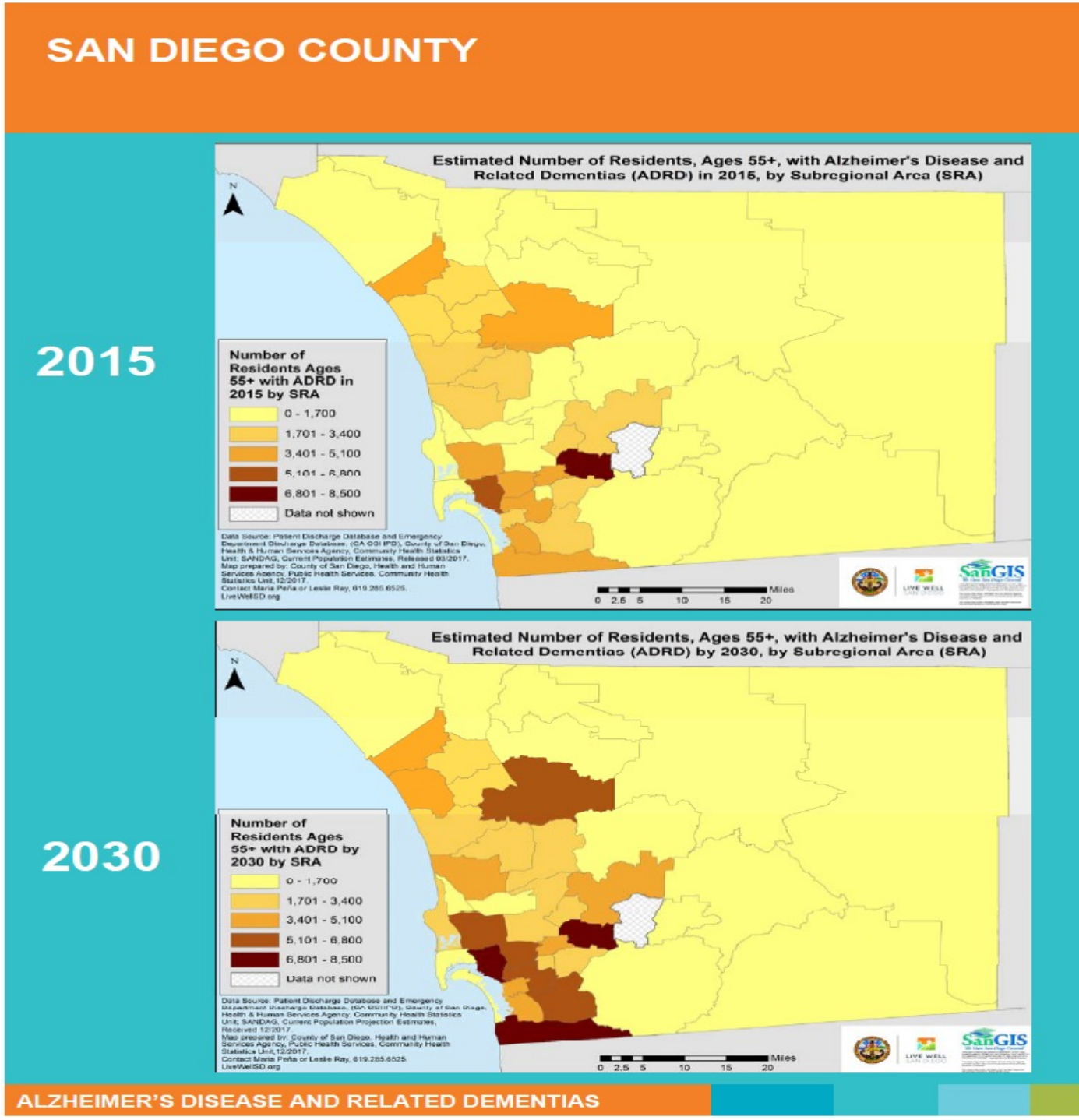
84,405 San Diegans >= 55 years old living with ADRD

By 2030:

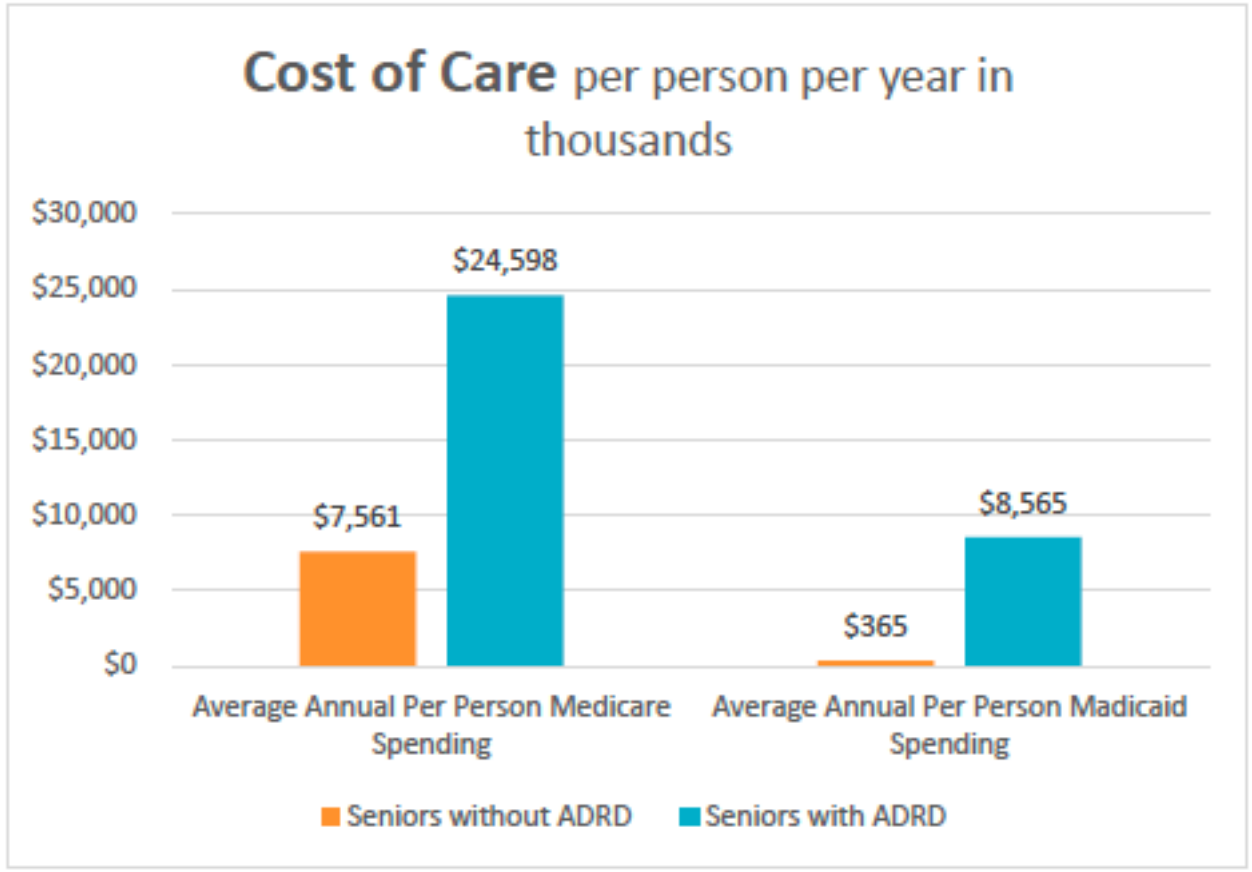
115,000 San Diegans >= 55 years old living with ADRD

ADRD: Alzheimer's Disease and related Dementias

www.SDHealthStatistics.com



Cost of Care per person With and Without ADRD



Source: Alzheimer's Association. 2019 Alzheimer's Disease Facts and Figures. Alzheimer's Dementia 2019;15(3):321-387.

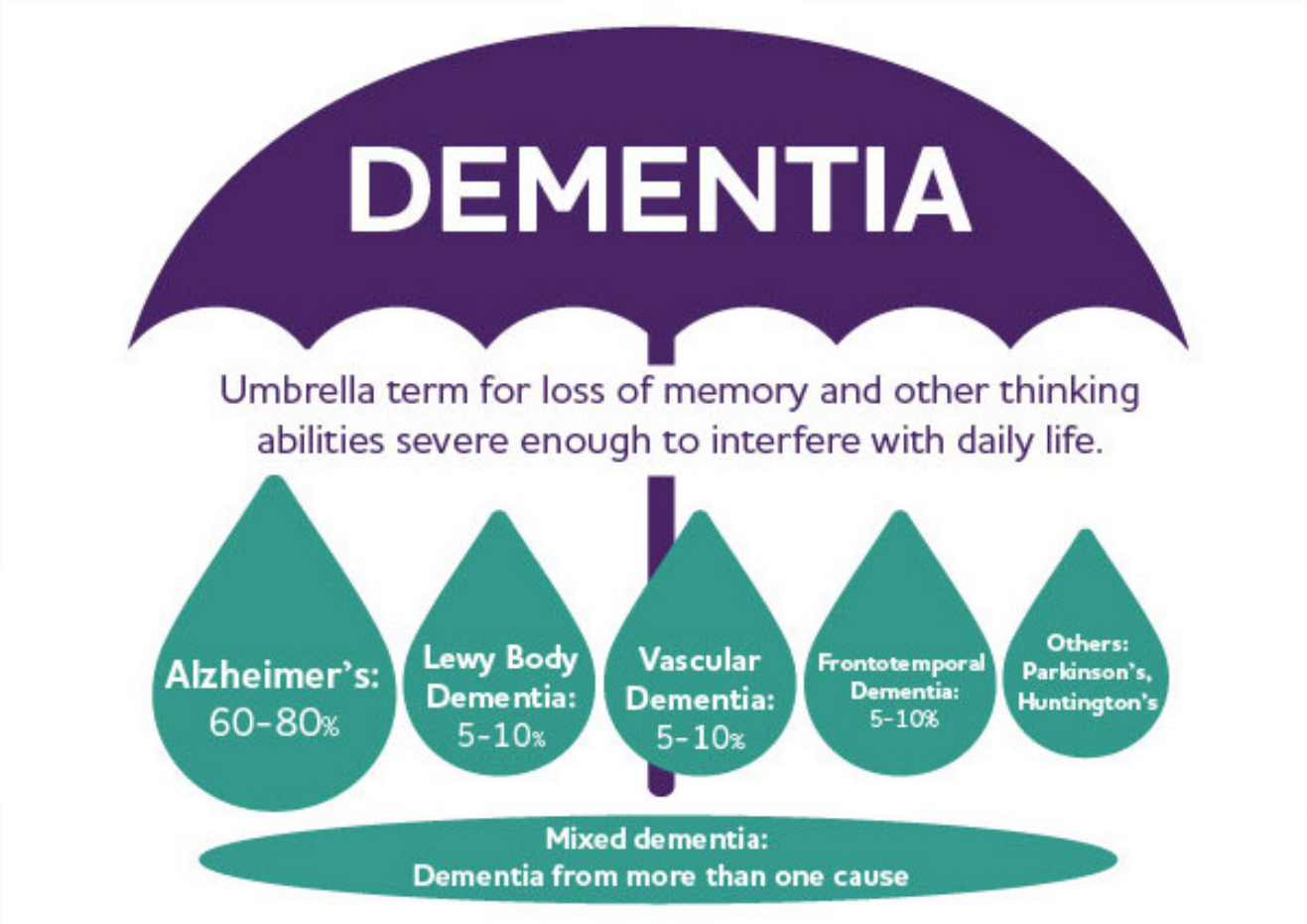
Patients with dementia cost Medicare 3X more than other beneficiaries in the same age group, primarily because of increased hospitalizations

Patients with dementia cost Medicaid 23X more, primarily because of increased nursing home placement

ADRD: Alzheimer's Disease and Related Dementias

MENTATION (MIND)

- **Dementia (Major Neurocognitive Disorder): An Umbrella Term**



https://www.alz.org/

MENTATION (MIND): Major Neurocognitive Disorder Criteria (Dementia)

DSM-5 Criteria Criteria for Major Neurocognitive Disorder	
1.	Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domain ➢ Learning and memory ➢ Language ➢ Executive Function ➢ Complex Attention ➢ Perceptual-motor ➢ Social Cognition
2.	The cognitive deficits interfere with independence in everyday activities (ADLs/IADLs)
3.	The cognitive deficits do not occur exclusively in the context of delirium
4.	The cognitive deficits are not better explained by another mental disorder (eg, major depressive disorder)

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, Arlington, VA 2013.

MENTATION (MIND)

Mind

Prevent, diagnosis, and manage delirium, depression, and dementia to enjoy what matters most

Reflection:

In your primary care practice, who do you evaluate for dementia (Major Neurocognitive Disorder)?

a) **Only patients who have a memory concern or whose family/friend has a concern**

b) **Screen every patient over 65 years old**

c) **It varies**

MENTATION (MIND): Screening and Evaluation

- USPSTF concludes there is insufficient evidence to recommend for or against routine screening for cognitive impairment in older adults (more research is needed)
  - *Although there is insufficient evidence to recommend for or against screening for cognitive impairment, there may be important reasons to identify cognitive impairment early*

- **The Medicare Annual Wellness Exam (AWV) requires an evaluation for cognitive impairment**

- **The IHI (Institute for Healthcare Improvement) Age-Friendly Healthcare Initiative recommends screening for cognitive impairment for every adult over age 65 at least annually**

TIPS

- **Normalize cognitive screening for patients. For example, say "I'm going to assess your cognitive health like we check your blood pressure, or your heart and lungs."**
- **Operationalize screening for cognitive impairment as part of Welcome to Medicare and the Medicare Annual Wellness Visits**
- **Always evaluate a new memory concern, regardless of timing**
- **If there is a sudden change in cognition, consider delirium**
- **Consider a mood disorder in the differential**

Case Presentation: Mr. Fox

Mr. Fox, a 74-year-old man presents to his primary care physician for follow up of his hypertension and sleep apnea. He is a retired middle school teacher. He does not have any symptoms or concerns today. His daughter called the clinic prior to the appointment to relay that she is worried about his memory because he has forgot to pick up his grandson from school twice in the past month.

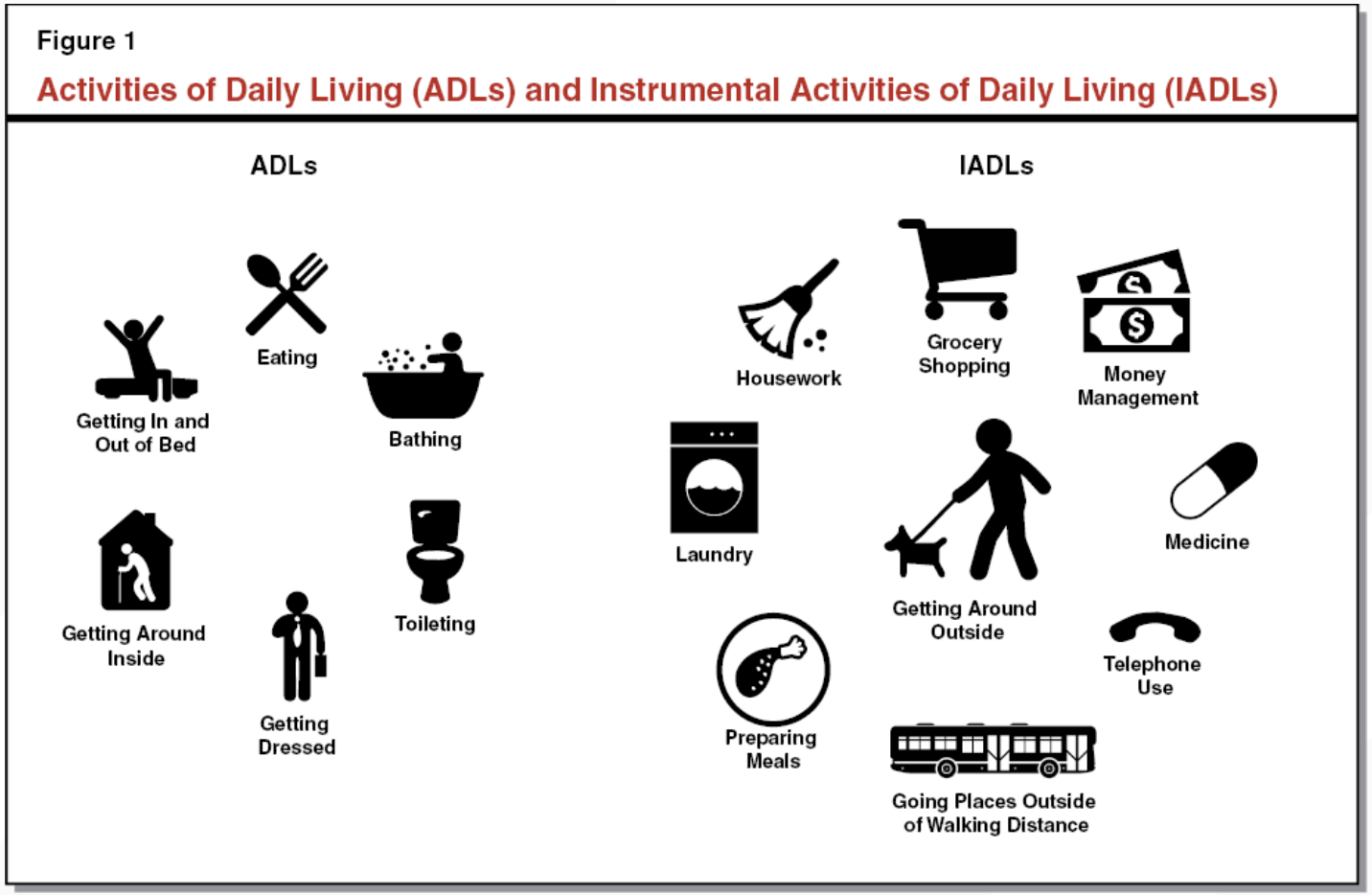
Having the Conversation: Cognitive History

1. **Over the past few months, have you or a member of your household noticed a decrease in your memory and/or other cognitive abilities that disrupts your daily life? (if yes, continue)**
2. Do you frequently misplace items and have difficulty or the inability to retrace your steps to find them?
3. Do you have problems finding the correct words?
4. Have you noticed you are withdrawing from work or social activities?
5. Are you having difficulty completing familiar tasks?
6. Have you or others noticed changes in your mood or personality?
7. Do you experience challenges in planning or problem solving?
8. Have you or others noticed decreased or poor judgment?
9. Do you experience trouble understanding visual images or spatial relationships?
10. Do you experience confusion with knowing the time or where you are?

Functional Status: the Sixth Vital Sign

Figure 1

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)



Back to the Case Presentation: Mr. Fox

The primary care physician asks Mr. Fox "During the past few months, have you or anybody around you noticed a problem with your memory?" He tells his PCP that he has not, but his daughter says he does. When you ask him more specifically about changes in his functional status, he confirms he is independent with ADLs including getting around the house, eating, grooming, and using the bathroom. He does share that he has had some trouble with missing payments for his credit card and sometimes getting turned around while driving. He does not otherwise have problems with orientation to time, place or self. He has no problems with word finding however he recently stopped going to meet up his friends to play cards because he was having trouble concentrating on the game.

Family History: Mother with Alzheimer's Disease
Social History: Lives alone. Occasional beer, no smoking. No recreational drug use.
Medications:
Amlodipine 5 mg daily
Trazodone 50 mg at bedtime
Vitamin D3 1000U daily

Physical Exam: unremarkable

Audience Participation:
Do you have a preferred validated cognitive screening tool to use at this point?

Screening for Dementia

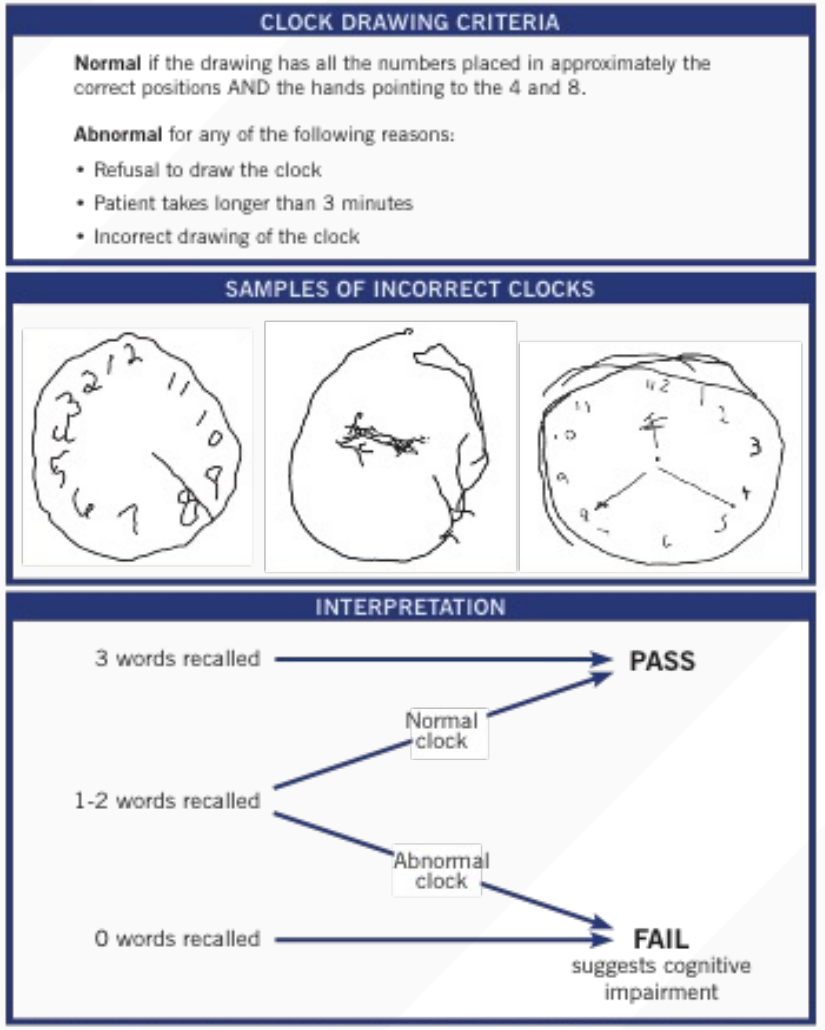
- Several Validated Tests
- Some Cognitive Assessments
  - Mini-cog
    - 3-word registration, clock drawing, 3-word recall
    - Sensitivity >80% and specificity of 60-80%
  - MOCA
    - Training now required
    - Validated for ages 55-85 and for several languages
    - Includes alternate forms for repeat administration
  - SLUMS
    - Free, multiple languages
- Informant questionnaires
  - AD-8
    - Sensitivity >84%, specificity >80%

Additional Considerations

- Hearing Impairment
- Vision Impairment
- Education
- Language

Mini-Cog Demonstration

Mini-Cog Scoring



Mr. Fox was able to recall all 3 items

AD8 (obtained from Mr. Fox's daughter)

Patient ID#:_____
Date:_____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	**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)		O	
2. Less interest in hobbies/activities	O		
3. Repeats the same things over and over (questions, stories, or statements)		O	
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)		O	
5. Forgets correct month or year		O	
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)	O		
7. Trouble remembering appointments	O		
8. Daily problems with thinking and/or memory		O	
TOTAL AD8 SCORE			

Audience Participation:
Do you have diagnosis?
Next Steps?

MENTATION (MIND): Major Neurocognitive Disorder Criteria (Dementia)

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American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, Arlington, VA 2013.

Case Continued: Mr. Fox

Labs:

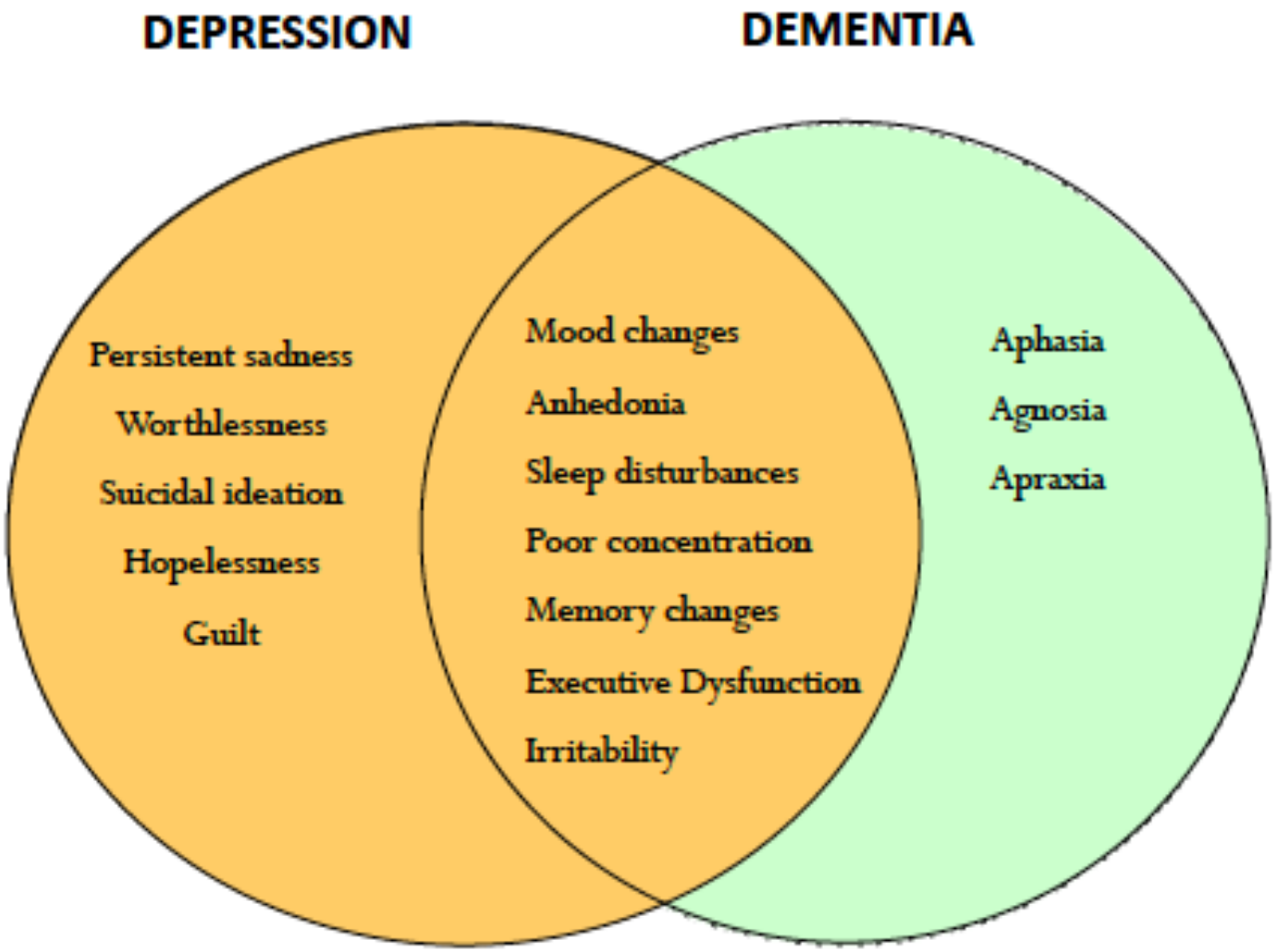
- CMP, CBC within normal limits
- TSH, folate, vitamin B12, vitamin D within normal limits

Other:

- PHQ-9 Score = 17

He endorses depressed mood, decreased interest, low energy, insomnia and poor concentration.

OVERLAPPING SYMPTOMS BETWEEN DEPRESSION AND DEMENTIA



Up to 20% of patients with Alzheimer's disease and up to 50% with vascular dementia also have a diagnosis of major depressive disorder

Note: Medical illnesses can also mimic depression and dementia, especially when a patient is delirious

Mr. Fox's Case Revisited: 3 Months Later

- His depression improved with initiation of sertraline and psychotherapy
- He started a daily walking routine and attending meets ups with friends
- Plan for continued monitor of his mood/cognition over time

Case 2: Mrs. Campbell

Mrs. Campbell presents to her primary care physician for a follow up visit accompanied by her daughter. She previously held a diagnosis of MCI based on cognitive changes that did not meet DSM criteria for dementia. However, her daughter reports that she has becoming more forgetful and has made several mistakes with recent bills and medications. Her daughter has now been setting up her pill box and double checking all bills.

Depression Screen:

- PHQ2 0/2

Cognitive Screening:

- MOCA one year prior: 26/30
- MOCA on day of the exam: 19/30 (missed points on trail-making, clock-draw, and delayed recall)

Labs:

- CMP, CBC within normal limits
- TSH, folate, vitamin B12, vitamin D within normal limits

MRI Brain:

- No acute intracranial process

Case 2: Mrs. Campbell

Her primary care physician completes a full dementia diagnostic evaluation, including a specialty referral for neuropsychologic testing, and determines she meets criteria for major neurocognitive disorder (dementia) since she has shown a decline in more than one cognitive domain by testing and history, her cognitive decline is interfering with activities of daily living and there is not another medical or psychiatric etiology to account for her cognitive decline.

After the primary care physician discloses a diagnosis of dementia, the doctor informs the patient and her daughter that a report to the DMV must be made regarding this new diagnosis. Both Mrs. Campbell and her daughter become very upset since they report she is still a good driver and taking away her license would cause her to lose her independence and risk social isolation. Mrs. Campbell's daughter, who works full time, is also worried about what her mom's needs will be as the dementia progresses because Mrs. Campbell lives alone.

Case 2: Mrs. Campbell

Her primary care physician completes a full dementia diagnostic evaluation, including a specialty referral for neuropsychologic testing, and determines she meets criteria for major neurocognitive disorder (dementia) since she has shown a decline in more than one cognitive domain by testing and history, her cognitive decline is interfering with activities of daily living and there is not another medical or psychiatric etiology to account for her cognitive decline.

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Audience Participation:
What resources can the PCP connect the patient and her daughter with?

Community Resources

Discussing Resources

- Can be an overwhelming process: where to start?
- Bill CPT code 99483
  - https://www.cms.gov/cognitive
  - Medicare can cover a separate visit for assessment and care planning
- Option of social workers or case managers from individual organizations or local agencies to work with individuals to navigate resources and individualize plans

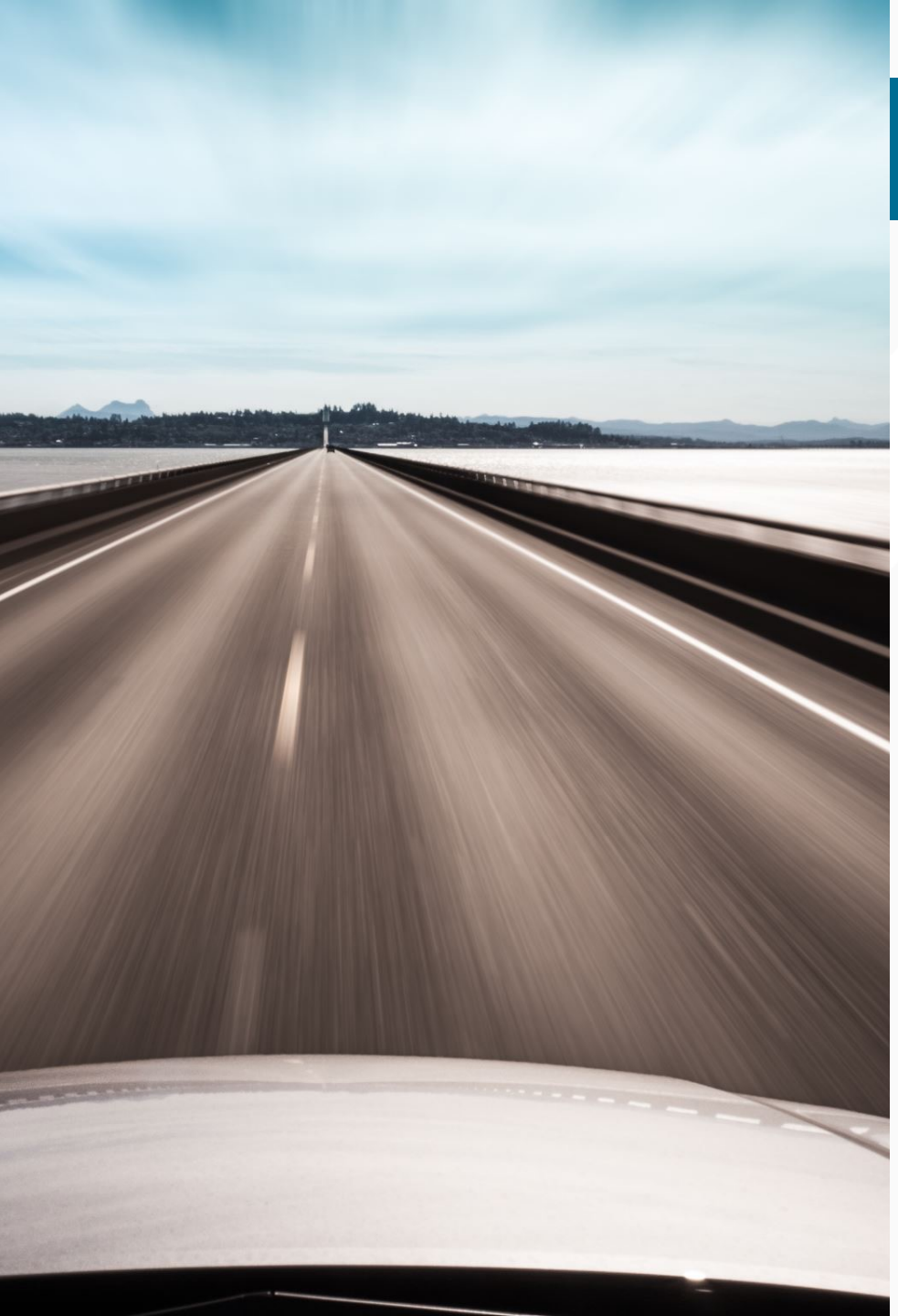
Resources

Types of resources available in the community

- Support Groups
- Quality of life programs
- Educational Material (classes, videos, podcasts, databases)
- Respite Care (Adult day centers, in home support)
- Placement options (Memory Care, SNF)
- Legal and Financial Resources
- Safety
- Transportation

Comprehensive list available on our website:

https://www.sandiegoimperialgwep.com/community-resources



Safety

- **Dementia and Driving**
  - Booklet on Balancing Independence and Safety
  - https://s0.hfdstatic.com/sites/the_hartford/files/at-the-crossroads-2012.pdf
  - Family Conversations Driving Kit
  - https://www.thehartford.com/resources/mature-market-excellence/crossroads-kit

Safety

- **Take Me Home Program**
  - Alzheimer's San Diego and the San Diego Sheriffs Dept. https://www.alzsd.org/new-take-me-home-enrollment-event/
- **Safe Return**
  - Alzheimer's Association 24/7 wandering support https://www.alz.org/help-support/caregiving/safety/medicalert-with-24-7-wandering-support
- **Gun Safety**
  - Alzheimer's San Diego Gun Lock Program https://www.alzsd.org/resources/safety/
- **GPS App**
  - Life 360 https://www.youtube.com/watch?v=Z-azbl4TShw&t=29s
- **Home Safety Checklists**
  - https://www.alz.org/media/documents/alzheimers-dementia-home-safety-checklist-ts.pdfnxnn
  - https://www.alzsd.org/home-safety-checklist-living-with-dementia/

Resources

At-A-Glance

Alzheimer's Association
https://www.alz.org/

- 24/7 helpline (800) 272-3900
- Community Resource finder
- Advocacy
- Educational Workshops
- Quality of life programs
- Access to social workers
- Support groups
- Research
- Referrals

Alzheimer's San Diego
https://www.alzsd.org/

- Educational Workshops (Take Charge Program)
- Quality of life programs
- Companion respite care
- Access to social workers
- Support groups
- Memory screening
- Research
- Referrals

Resources

At-A-Glance

Southern Caregiver Resource Center (SCRC)

https://www.caregivercenter.org/

(Many resources in Spanish and also across SD and Imperial Counties)

- Respite care (Together Care)
- Education and Training (REACH2Caregivers)
- Access to social workers
- Short-Term Counseling
- Support Group
- Legal and Financial Consultation
- Employer Resources
- Operation Family Caregiver

The Glenner Centers

https://glenner.org/

- Adult Day Program
- Support Groups
- Glennercare™
- Memory Café
- Dementia Care Education (Professional Caregivers)

Resources

At-A-Glance

- **UCSD Shiley Marcos Alzheimer's Disease Research Center (SMADRC)**
  https://medschool.ucsd.edu/som/neurosciences/centers/adrc/Pages/default.aspx
  - Quality of life programs
  - Access to social workers
  - Memory screening
  - Referrals
  - Research
  - Resources

https://medschool.ucsd.edu/som/neurosciences/centers/adrc/community/learn-about-dementia/Documents/ADResourcesPacketUpdated-FINAL.pdf

Resources for Other Related Dementias

At-A-Glance (Helpline, Support Groups, Online Education, Research)

- **The Association for Frontotemporal Degeneration (AFTD)**
  https://www.theaftd.org/
- **Lewy Body Dementia Association**
  https://www.lbda.org/
- **Parkinson's Association of San Diego**
  https://parkinsonsassociation.org/

Legal and Financial Resources

- Advanced Health Care Directives
- Durable Power of Attorney
- Estate Planning
- Conservatorships
- **Legal and Financial Basics Webinar Presented by Alzheimer's San Diego**: https://www.youtube.com/watch?v=zrzCSwNnwfA&list=PLQdvPXSt8kRaHgMXXjAJdswjvQcLovoaa&index=7
- **Elder Law and Advocacy**: Non-profit, which offers free legal help for qualifying older adults and their caregivers: 858-565-1392
  - **Senior Legal Services** provides legal counseling and advice, legal document review and preparation, negotiation, small claims assistance, and public education and outreach.
  - **Nursing Homes Rights Enforcement Project** advocates for and assists patients in skilled nursing facilities that provide both intermediate and long-term care to low income or underserved seniors in San Diego and Imperial Counties.
  - **Health Insurance Counseling and Advocacy Program (HICAP)** provides assistance with Medicare and health insurance issues to Medicare beneficiaries and those persons approaching the age of Medicare eligibility.
  - **Family Caregiver Legal Services** is designed to assist adult family caregivers or elderly persons who have dementia, who are economically and socially disadvantaged, or isolated, homebound, or institutionalized. Services include legal counseling, advice, and advocacy.
  - **Elder Abuse Representation Project** provides free legal assistance to victims of Elder Abuse seeking to obtain an Elder Abuse Restraining Orders and offers litigation services with other civil matters of Elder Abuse.
  - **Elder Tenant Assistance Project** offers pre-litigation legal services to seniors who are at risk of homelessness due to a threat of eviction or uninhabitable living conditions.

Dementia in Primary Care: Common Struggles

- Having enough time
- Competing priorities
- Disclosing a dementia diagnosis
- Mixed data regarding effectiveness of medications
- Heterogeneity of dementia prognosis
- Obligation to report to the DMV (California)
- Providing adequate support as dementia progresses
- Caregiver burden

Dementia in Primary Care

Audience Participation

- Would anybody like to share cases or questions that they struggle with in screening, evaluating, or managing dementia for older adults in clinic?

Billing

Who counts as a billing provider?

Medicare	Medi-Cal
Physicians (MD and DO) Nurse Practitioners Physician Assistants Clinical Nurse Specialists	Physicians (MD and DO) Nurse Practitioners Supervising Physicians on behalf of Physicians Assistants

https://www.dementiacareaware.org/page/show/139864

Coverage	Visit Type	Billing Code	Things to know
Dual-eligible or Medicare only beneficiary	Initial Annual Wellness Visit	G0438	You can use the cognitive health assessment to satisfy the required AWV cognitive impairment screen
Dual-eligible or Medicare only beneficiary	Subsequent AWVs	G0439	You can use the Cognitive health assessment to satisfy the required AWV cognitive impairment screen
Dual-eligible, Medicare only, and Medi-Cal only beneficiary‡	Cognitive Assessment and Care Planning (50 minute)*	CPT code 99483	The cognitive health assessment **alone** does not meet criteria for this code. To use this code, required elements include: - Evaluation of cognitive level (cognitive health assessment can be used) - Complexity of medical decision making by the clinician noted as moderate to high - Review and reconciliation of medications - Assessment of function levels-ADLs and IADLs (cognitive health assessment can be used) - Stage severity of dementia using standardized instruments - Evaluation of neuropsychiatric and behavioral symptoms (including depression) - Evaluation of safety (home safety and driving) - Identification of caregivers (knowledge, needs, social supports, willingness to take on caregiving tasks) (cognitive health assessment can be used) - Advance care planning - Creation of a person-centered care plan
Medi-Cal only beneficiary†	Cognitive health assessment	1494F	Billing provider must complete the Dementia Care Aware cognitive health assessment (CHA) to use the billing code.

Dementia Care Aware Initiative

https://www.dementiacareaware.org/

DEMENTIA
Care Aware
Early detection. Better care.

What is Dementia Care Aware?

Dementia Care Aware is a training and support program that empowers primary care teams to assess and address dementia. We provide on-line training on an initial 5-min Cognitive Health Assessment (CHA) and additional training on important topics and resources for the next steps in evaluation and care planning with patients. We also provide resources for caregivers and implementing dementia detection and care in clinical practice.

Practice Support

We help providers and practices implement the CHA in practice with resources that fit your bandwidth:

- Centralized **warmline support** for clinical management or consult questions Mon-Fri from 9am to 5pm.
- Virtual, live education and case conferences on the CHA and dementia care.
- Practice support coaching to implement dementia care in your practice and get hands-on, customized practice improvement guidance.

SD Alzheimer's Project Initiative and Champions for Health

THE ALZHEIMER'S Project
San Diego unites for a cure and care

WWW.SDALZHEIMERSPROJECT.ORG

The Alzheimer's Project, initiated in 2014, aims to address the devastating toll of Alzheimer's disease and related dementias in San Diego County. It brings together teams of experts and decision-makers that include members of our region's top political leadership, research institutions, public universities, health care systems, caregiver groups, and other community organizations. Each of these teams convenes to discuss recommendations in four key focus areas of the initiative:

Collaboration4Cure unites scientists and experts to identify strategies to support local Alzheimer's research efforts towards finding a cure

The **Clinical Roundtable** brings together healthcare providers to discuss strategies to equip practitioners with the knowledge and resources necessary to improve medical care for those with dementia

The **Care Roundtable** calls together Alzheimer's caregivers and senior care organizations to explore ways to improve the impact and delivery of services

Public Awareness & Education focuses on providing comprehensive, dementia-related information to all San Diegans through various communication channels to increase community knowledge of the disease and its impact on our region

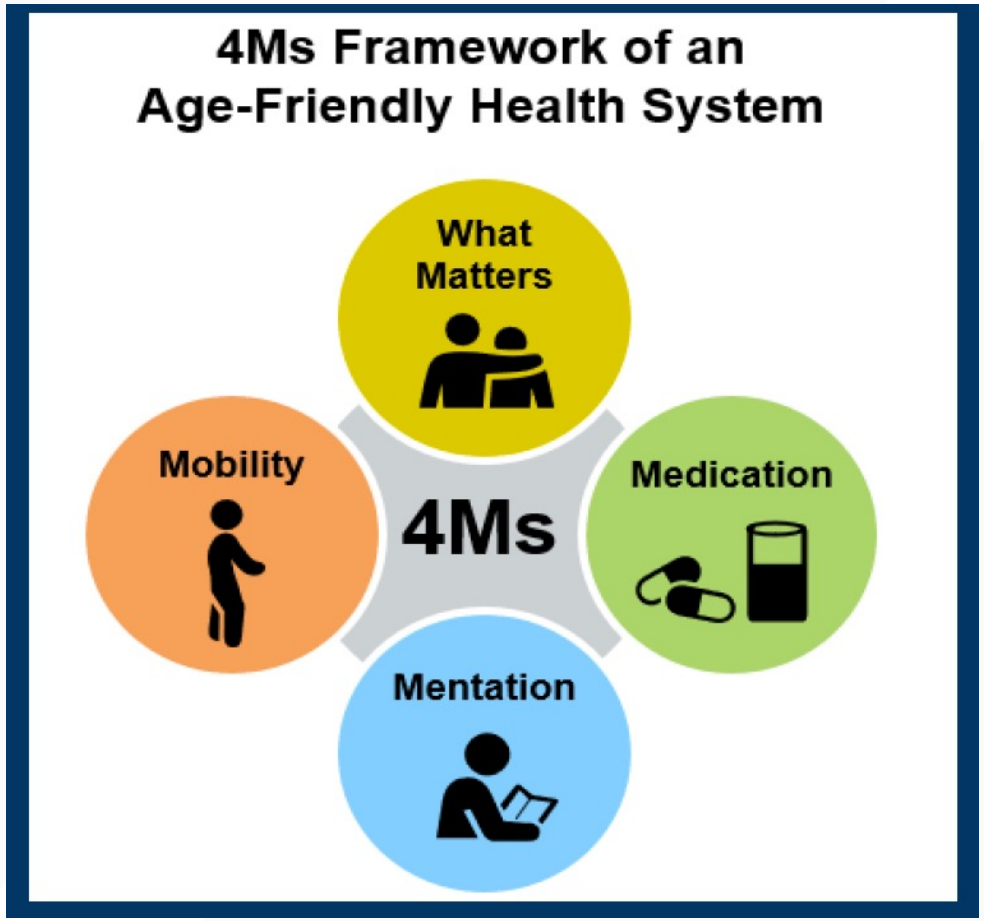
CHAMPIONS for HEALTH | PHYSICIANS IMPROVING HEALTH CHANGING LIVES

https://championsforhealth.org/alzheimers/

THE ALZHEIMER'S PROJECT CLINICAL ROUNDTABLE AND GUIDELINES

Primary care physicians and providers can screen and evaluate for Alzheimer's disease and related dementias with more confidence and ease, and access tools to manage behavioral issues. The Alzheimer's Project Clinical Roundtable, a group of neurologists, psychiatrists, geriatricians, and geriatric psychologists, have been working since 2015 to develop tools to assist the primary care providers who will care for the vast majority of patients experiencing cognitive decline, as well as assist their family members and caregivers.

Refresher on 4Ms of Age-Friendly Care



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Know and align care with what Matters to each older adult

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Mentation / Mind

Prevent, diagnosis, and manage delirium, depression, and dementia to enjoy what matters most

Delirium

Confusion Assessment Method (CAM) for the Diagnosis of Delirium*	
1.	Acute and Fluctuating Course
2.	Inattention
3.	Disorganized Thinking
4.	Altered level of consciousness

*The diagnosis of delirium requires the presence of #1 AND #2 PLUS either #3 or #4

Case 3: Ms. Gomez

Ms. Gomez is an 80 year old woman admitted to the hospital for treatment for sepsis from a UTI. While hospitalized, she becomes confused and begins pulling at her IV lines and difficult to redirect even with a 1:1 sitter. She is diagnosed with delirium due to her underlying infection. She clinically improves with fluids and antibiotics and is discharged on day 5 of her hospitalization.

She misses her post-discharge follow-up appointment so she is next seen by her primary care physician 3 months later. Her family reports that she continues to be confused at times since her hospitalization, though it gets better and worse. They are concerned that she is developing dementia.

Audience Participation:

How would the primary care physician know if this is dementia or delirium?

Delirium vs Dementia

Table 2 – Differentiating delirium from dementia

Characteristic	Delirium	Dementia
Onset	Acute	Insidious
Course	Fluctuating	Gradual deterioration
Awareness	Impaired	Often clear until advanced stages
Attention	Disturbed	Often good until advanced stages
Memory	Poor working memory and immediate recall	Poor short-term memory
Delusions	Often short-lived or changing	More fixed
Sleep disturbances	Fragmented sleep	Sleep-wake reversal

https://www.psychiatrictimes.com/view/understanding-and-treating-delirium

Delirium in Primary Care

- 30% of older adults experience delirium at some time during hospitalization
- Signs of delirium may persist for 12 months or longer, particularly in those with underlying dementia
- Delirium has primarily been studied in hospital settings, however, remains on the differential for new cognitive change in the outpatient setting

Summary of the 3Ds for Age Friendly Health Systems

Systematically assess for dementia, delirium, depression

	Dementia	Depression	Delirium
Assess (History + Validated Tool)	Mini-Cog MOCA (Montreal Cognitive Assessment) SLUMS (St. Louis University Mental Status Exam) AD8 (Informant Questionnaire)	GDS (Geriatric Depression Scale) PHQ-9 (Patient Health Questionnaire) PHQ-2 (Patient Health Questionnaire)	CAM (confusion assessment method)
Manage	Patient/Family Education Identifying Support Structure Community Resources Medications	Counseling Referrals Medications	Treat the underlying cause (pain, constipation, infection, etc)

Take-Home Message

- Dementia is common and will become more common as our population ages
- Age-Friendly Healthcare requires a systematic approach to assessing mentation (including dementia, depression and delirium) in older adults on a regular basis
- Community Resources are critical to help providers, caregivers, and patients living with dementia

Evaluating cognitive and functional decline often takes repeat assessments and updates over time

Ongoing Assessments

- ❑ Evaluation of cognition (consider all elements of DSM-5 criteria) with repeat cognitive/functional assessment over time
- ❑ Identify any safety concerns
- ❑ Documentation of social support and/or health care agent
- ❑ Consider appropriate community resources
- ❑ Counseling regarding brain health

THANK YOU FOR YOUR TIME!

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