NEUROPSYCHOLOGY AND PSYCHOTHERAPY

Considerations for Evaluation and Referral in Primary Care

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DISCLOSURE

I have no financial relationships with commercial interests to disclose.

OBJECTIVES

- Identify aspects of patient history relevant to questions of suspected cognitive decline.
- List and discuss at least three tools for in-office cognitive and functional screening.
- Identify patients appropriate for referral for formal neuropsychological testing and/or psychotherapy.

THE INSPIRATION

1968

1984

WHY SCREEN IN PRIMARY CARE?

- Aging Population and Scope of Problem

- Currently, diagnosis often comes late
  - Many never receive formal diagnosis
  - Years after onset of signs/symptoms
  - Often at point of major functional changes and/or crisis
  - Many reasons for this
    - Patient Barriers
    - Provider Barriers
    - Systemic Barriers

SO, YOU MIGHT BE THINKING….

WHY SCREEN IN PRIMARY CARE (CONT.)?

- Limited availability of specialists and evidence that GP's can diagnose and manage many of these patients

- Increasing data that early identification of decline and intervention can delay onset or slow progression
  - Neuroplasticity throughout life
  - Improve quality of life
  - Advanced planning
  - Tremendous cost savings
  - Reduction of caregiver stress

PRESENTING CONCERNS

- Patient or family member(s) reports concerns about memory or other cognitive change
- You notice possible concerns during a regularly scheduled visit (i.e., change from previous, confusion, word finding issues, etc)
- Non-memory changes
  - Personality Change
  - Late life onset of significant psychiatric symptoms
- **May not be the presenting issue. Goal is to start looking for it in those 65+.**

NORMAL AGING VS. MILD COGNITIVE IMPAIRMENT (MCI)

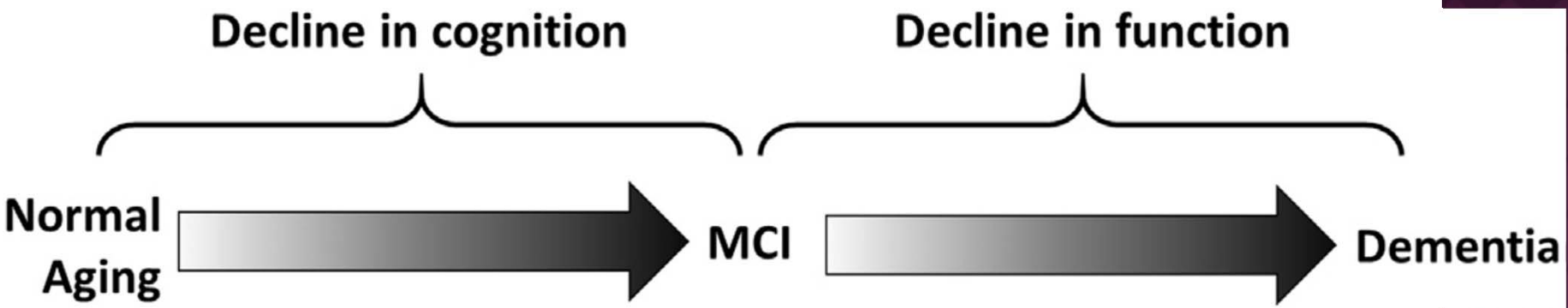
- Normal Aging
  - Slower processing but intelligence remains
  - Decreased mental flexibility
  - Occasional forgetfulness or word finding issues
- MCI
  - Difficulty with memory or other core brain functioning
  - Problems are severe enough to be noticeable to others and to show up on screening tests
  - Problems are NOT severe enough to interfere with daily life (i.e., functioning)

MCI VS. DEMENTIA

- Dementia
  - Clear cognitive deficits
    - Recent memory
    - Language
    - Executive functions (judgment, planning, reasoning)
    - Perceptual-motor
    - Social cognition (apathy, inappropriate social bx)
  - Functional impairment
  - Impairment is progressive in nature and not otherwise explained

DSM-5: “The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex activities of daily living such as paying bills or managing medications).”

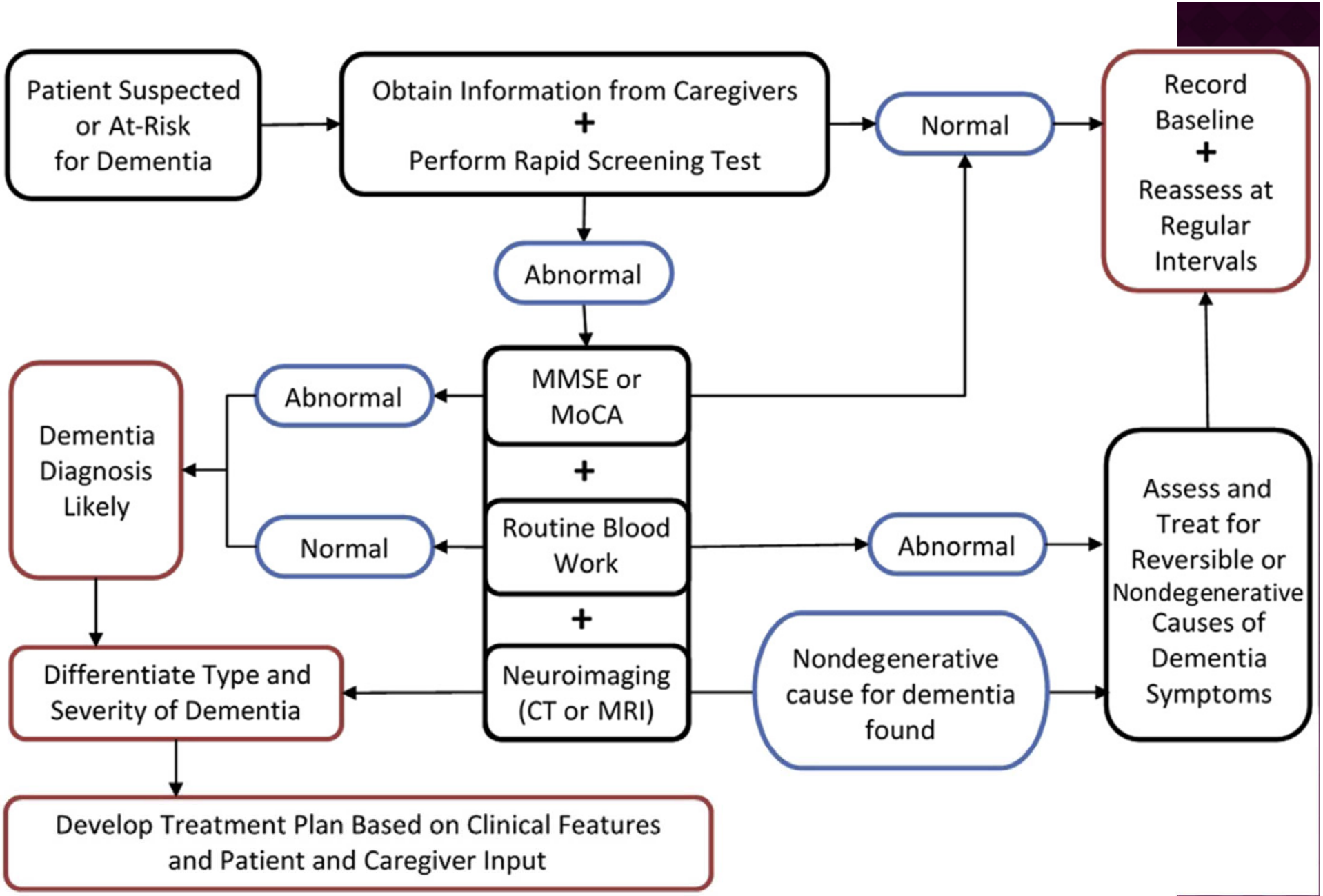
THE DIAGNOSTIC CONTINUUM



Moga, D. C., Roberts, M., & Jicha, G. (2017). Dementia for the Primary Care Provider. *Primary Care, 44(3)*, 439-456.

HISTORY

SCREENING
Cognitive
Functional



Moga et al. (2017)

STEP 1- INFO WITH INFORMANT AND RAPID SCREENING

- During the past 12 months, have you experienced any change in memory, language, or decision making?
- Do you need help from others to take care of things like your medicines, finances, transportation, or food preparation?

AND

- Choose one of Step 1 Rapid Screening Tests
  - If negative and no complicating factors – Record as baseline and reassess in 1 year
  - If positive, proceed with further evaluation (schedule another appt as well as labs/imaging)

HISTORY – INCLUDE INFORMANT

- History of symptoms related to cognition
  - First, verify that it is a CHANGE
  - Nature of changes and examples
  - Timeline of changes – any correlated changes
- Family history of memory problems with age or Dementia
- Relevant medical/neurological history

OTHER HISTORY

- Substance Use/Abuse History
- Mental Health Symptoms and History
- Educational/Occupational History
- Current Living Situation/Support
- Sources of recent/current stress

STEP 1 - SCREENING TOOLS

- Mini-Cog http://mini-cog.com
  - Consists of 3-word verbal recall and Clock Draw
  - 0-5 points; Score of 3 or less = fail

- General Practitioner Assessment of Cognition (GPCOG) http://gpcog.com.au
  - Name and address for recall
  - Time orientation (Date)
  - Clock Drawing
  - Information/Current Event
  - 0-9 points; Below 5 = fail, Scores of 5 - 8 suggest proceeding to **Informant Interview**

STEP 1 - SCREENING TOOLS (CONT.)

- Memory Impairment Screen
  - https://www.alz.org/media/Documents/memory-impairment-screening-mis.pdf
  - 4-Item Recall with Category Component
    - Free Recall and Cued Recall after 2-3 mins distraction
    - 2 points for Free Recall; 1 point for Cued Recall
  - O-8 Points; ≤4 = Impairment

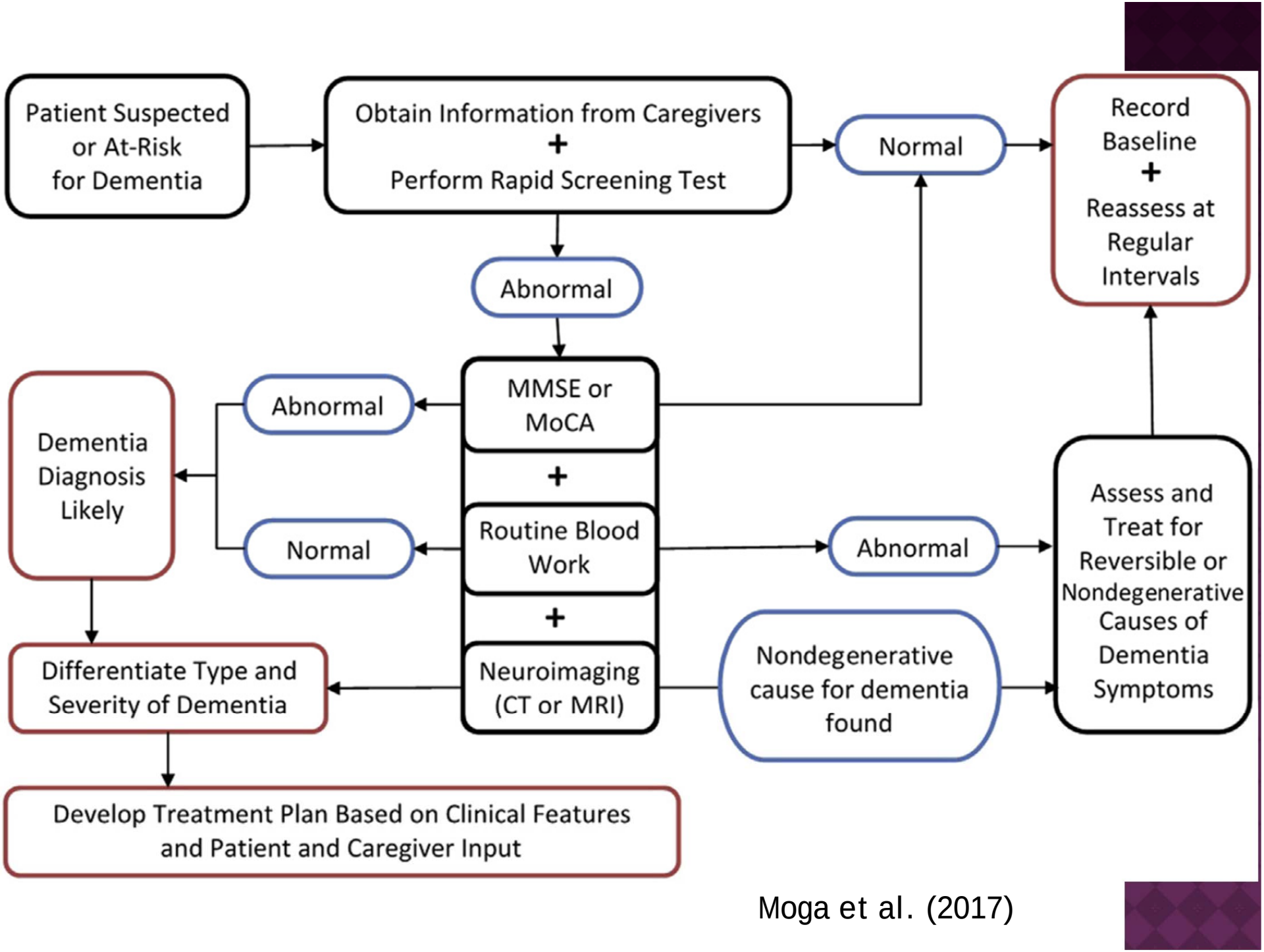
CHECKERS
SAUCER
TELEGRAM
RED CROSS

STEP 1 - SCREENING TOOLS (CONT.)

- Ascertain Dementia 8-Item Informant Questionnaire (AD-8)

  http://alzheimer.wustl.edu/cdr/AD8.htm

  - Informant based test
    - Asks informant to rate patient change in areas of judgment, aspects of memory, and functioning.
  - Range 0-8 (1 point for each item rated as changed); 2+=Likely impairment
  - Similar sensitivity and specificity to GPCOG but takes less than 2 minutes
  - Particularly useful in individuals with low education



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STEP 2 – COGNITIVE SCREENING TOOLS

- Mini Mental State Exam (MMSE)
  - 24-30 – Considered within normal limits
  - 18-23 – Mild Impairment
  - 0-17 – Severe Impairment
- Montreal Cognitive Assessment (MoCA)
  - http://www.mocatest.org/
  - Possible 30 points
    - 26+ is considered Normal
    - 18-26 MCI
    - Below 18 suggests dementia
      - 10-17 Moderate Impairment
      - Less than 10 Severe Impairment

- MMSE
  - Introduced in 1975
  - Quick and easy (7-8 minutes)
  - Frequently used
  - 30 Points Possible

  Good choice in more severe/obvious cases or in low functioning individuals.

- MoCA
  - Introduced in 1996
  - Takes a bit longer to administer (10-15 minutes)
  - Screens multiple domains
  - More sensitive
  - 3 free versions – English + translations
  - Increased standardization
  - Includes some correction for education

  Better choice for milder impairment and/or high baseline.

MOCA

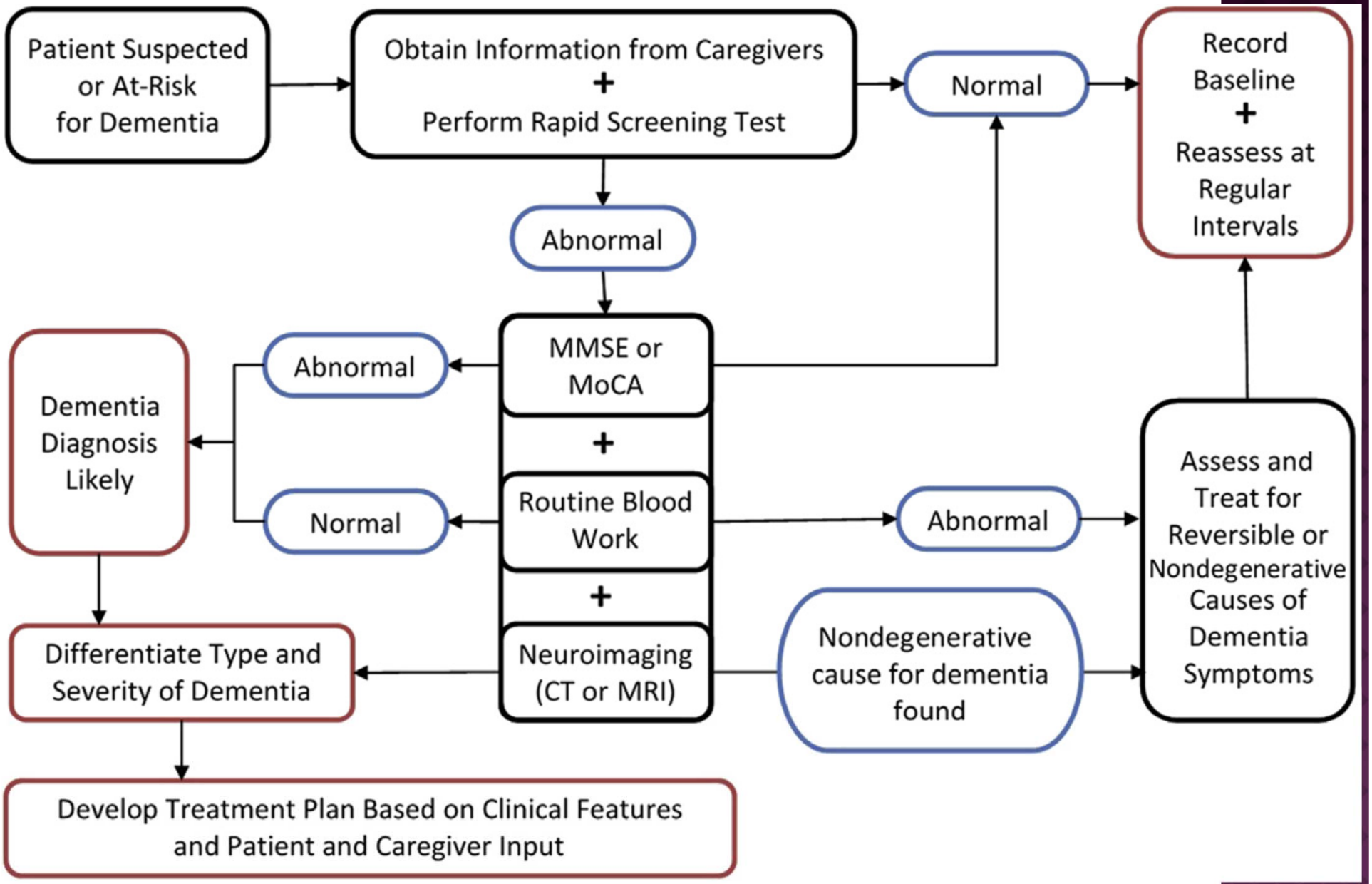
https://www.mocatest.org/paper-tests/moca-test-full/

FUNCTIONAL ASSESSMENT

- ADL's
- FADL's
  - Medication Management
  - Handling Finances
  - Driving
  - Cooking
  - Technology – cell phones/computers/RC's
  - Anything they used to do regularly but now seems too confusing or frustrating

DEPRESSION SCREENING

- Look for history and symptoms during regular visit.
- Query patient and informant regarding mood changes and enjoyment of activities.
- Depression Screening – PHQ-9 or GDS
- If there appears to be significant component of depression, initiate treatment and schedule follow-up.



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EVIDENCE OF DECLINE, NOW WHAT?

- Medical Work-Up
  - History
  - Labs
  - Imaging

- Educate Patients on Brain Wellness Program
  - Eat Well (Mediterranean or MIND Diet)
  - Get Moving
  - Stay Sharp (i.e., cognitive activity)
  - Be Social
  - Meditation

  www.Idph.iowa.gov/Save-Your-Brain

NOW WHAT? (CONT.)

- Evaluate medication list for Anticholinergics
- Consider medication treatment
- Monitor for depression
- Provide referrals
- Provide SUPPORT

WHEN TO REFER - MEMORY CLINIC AND/OR NEUROPSYCH TESTING

- High baseline
- Low baseline
- Strong mental health history or symptoms
- Unusual course
- Discrepancy between patient report, family report and/or observation that interferes with establishing plan
- Patient or family request
- Safety concerns or legal issues
- Feels unclear for any reason

NEUROPSYCHOLOGICAL TESTING

Traditional testing batteries (e.g., Halstead-Reitan or Luria Nebraska may take 4-8 hours)

PROS:

- Thorough and informative
- Certainly, populations and referral questions that warrant this

CONS:

- Difficult to find provider
- Insurance coverage
- Difficult to tolerate

NEUROPSYCHOLOGICAL SCREENING FOR DEMENTIA

2-Hour Evaluation that consists of more detailed version of above:

- History with patient and informant(s)
- Cognitive Testing
  - Measure to estimate baseline
  - Memory
  - Executive Functioning (speed and reasoning)
  - Language
  - Apraxia Screening
- Functional Assessment
- Depression Screen

MAKING A REFERRAL

- Be mindful of limited availability and consider in-office screening

- If referral is necessary, please send:
  - Patient Demographics – contact info for patient and family member if appropriate
  - Insurance Information
  - Recent Progress Notes relevant to referral
  - Lab Results and Brain Imaging Report
  - Referral Question

EXAMPLE REFERRAL QUESTIONS

- Patient scores well on screening measures (MOCA = 27/30) but family is quite concerned about memory decline. Please evaluate for MCI or early dementia.

- Patient with history of significant depression. Positive family history of dementia, and he is anxious about forgetfulness. Please evaluate.

- Conflict over financial matters. Family believes patient is “incompetent.” Scores 20/30 on MMSE. DHS is involved and requesting formal evaluation.

NEUROPSYCH REPORT

- Report will contain summary of:
  - Relevant History
  - Test Results
  - Observations/Mental Status
- Summary and Recommendations
  - Presence or absence of deficits relative to gender/age/education
  - Diagnostic formulation

NEUROPSYCH REPORT (CONT.)

- Recommendations May Include
  - Statement related test performance and decision making ability
  - Notations of safety concerns (e.g., driving, adequacy of living arrangements)
  - Brain Wellness recommendations
  - Proactive planning notes
  - Further evaluation recommendations (e.g., brain imaging or other specialist)
  - Follow-up with PCP to discuss interest in medication treatment
  - Comments and recommendations related to mental health/emotional concerns
  - Recommendation for consideration of re-evaluation

ACTUALLY, I'M MOST CONCERNED ABOUT DEPRESSION

Isn't that normal in older adults?

NO, it's actually not.

Common, but not normal.

Estimates are between 5-21% meet criteria for depression.

IS PSYCHOTHERAPY USEFUL IN OLDER ADULTS?

YES

PSYCHOTHERAPY IN OLDER ADULTS

- Indications
  - Depression or Anxiety (Not loneliness)
  - Grief / Coping with Loss
  - Patient reveals unresolved issues

- Contraindications
  - Significant dementia (consider support groups and/or therapy for caregiver)
  - Gross psychosis
  - Patient declines referral

MAKING A REFERRAL

- Therapy
  - Refer as you would refer a younger person – consider those who specialize with older adults

  https://www.psychologytoday.com/us/therapists?search=50314
- Support
  - Those who would benefit from "someone to talk to"
  - Consider community supports and/or support groups
  - Aging Resources or Alzheimer's Association

CAREGIVER SUPPORT

- Alzheimer's Association has list of caregiver local support groups
- Aging Resources – Information regarding services, respite, placement if needed.
- Acknowledge and validate the experience of strain on family
- Suggestion of therapy for caregiver

A LITTLE SECRET…

- Some of the most important aspects of "therapy" don't require a therapist
- Things you can do during a regular office visit that are free, take virtually no time, and can make all the difference
  - Provide validation and support
  - Empathize
  - Look for any opportunity to reinforce positives and offer hope
  - Assure the patient and family that they are not alone


“Wherever there is a human being, there is an opportunity for kindness.”
- Seneca -

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