Dementia: Risk Factors, Screening and Diagnosis, and Promising New Interventions

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Disclosures

• None
Disclosures

• Learning Objectives/Overview
  – Risk factors
    • Modification
    • Risk Reduction
  – Cross cultural issues
    • Health disparities
    • Evaluation
    • Treatment
  – Bree Collaborative updates
    • Screening, diagnosis and treatment
    • Medicare Annual Wellness Visit
    • Medicare billing codes
  – Non-pharmaceutical interventions
Increased Life Expectancy and Epidemic of Alzheimer’s

- 10,000 Americans reach 65 each day
- Current life expectancy 78 years
  - 47 years in 1900
- **Age** is single greatest risk factor for Alzheimer’s disease
- 80 million Baby Boomers (born 1946-1964)
2018 Facts and Figures

Projected Number of People Age 65 and Older (Total and by Age Group) in the U.S. Population with Alzheimer's Dementia, 2010 to 2050

• **Third most costly health condition in 2015**
  - Annual cost ~ $227 billion
  - $172 billion in 2010
  

• **$604 Billion worldwide in 2010**
  - $238 billion/year = (T2DM+CAD+HTN+CVA)
  
  Wimo & Price 2010

• **83% of US workers obese or w/chronic condition**
  - > $1 trillion/year lost economic activity and productivity

• **$7.9 trillion cost savings with early detection**

Dementia, Healthcare & Economic Burden

• Major risk factor for critical patient safety issues
  – Post-op delirium
  – Hospital delirium
  – Falls
  – Rapid readmission rates  
  \[\text{Wimo & Price 2010}\]

More broadly family caregiver’s accelerated aging

• Increased area of focus for Accountable Care
  – WA Alzheimer’s State Plan
  – Bree Collaborative
  – Puget Sound High Value Network
Alzheimer’s in Washington State

- 110,000 cases in WA
  - 27% increase by 2025

- 3rd leading cause of death
  - 4th highest rate in the US
  - Mortality rate= 48.7

- Who provides care?
  - 341,000 unpaid caregivers
  - 389,000,000 hours = $4.9 billion
  - $237 million in additional health care costs

Rethinking Memory Loss

- Inevitable consequence of aging
- Stigma
- Chronic disease model
- Prevention
- Rehabilitation
- Treatment
- Palliative care
The Lancet Commission presents a new life-course model showing potentially modifiable, and non-modifiable, risk factors for dementia.

Risk factors for dementia

- Smoking (5%)
- Depression (4%)
- Physical inactivity (3%)
- Social isolation (2%)
- Diabetes (1%)

- Potentially modifiable: 35% - 30% (Potentially non-modifiable: 65% - 70%)

Percentage reduction in new cases of dementia if this risk is eliminated

Early life
- Less education (3%)
- Hyperactive/impulsive (2%)
- Hearing loss (1%)

Middle life
- Hypertension (2%)
- Obesity (3%)
- Diabetes (1%)

Late life
- Smoking (5%)
- Depression (4%)
- Physical inactivity (3%)
- Social isolation (2%)
- Diabetes (1%)

Livingston et al., 2017
Normal Memory Loss

Cognitive Functioning

Age

Early Life  Late Life
Abnormal Memory Loss

- Cognitive Functioning
- MCI
- Dementia

Early Life
Late Life
Age
Mild Cognitive Impairment (MCI)

- Memory complaints/impairment
  - ~1.5+ SD difference (norm vs. premorbid)

- Otherwise normal cognitive function

- No functional impairment

- Subtypes
  - Amnestic
  - Single domain, nonamnestic
  - Multiple domain (amnestic vs. non)
Mild Cognitive Impairment

- Amnestic MCI ~10% /year convert to AD

- Multiple Domain MCI
  - Alzheimer’s disease
  - Vascular Dementia/Mixed (VCI)
  - Normal aging

- Single non-memory domain MCI
  - Frontotemporal Dementia
  - Lewy Body Dementia
  - Alzheimers Dementia
• Clinical Presentation: A syndrome of acquired impairment of memory and other cognitive domains sufficient to affect daily life.

• Etiology: Any disorder causing structural damage to brain systems involved in memory.
# Etiology: The Less Usual Suspects

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<td>Wilson’s disease</td>
<td>Liver Disease</td>
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<td>Chronic hypoglycemia</td>
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<td>Certain cerebellar ataxias</td>
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<td>Tay Sachs</td>
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Dementia: Risk Factors

Related health conditions:

- Smoking
- Alcohol
- Sitting disease/Sedentary lifestyle
- Depression
- Sleep apnea
- Delirium
- Hospitalization/Sepsis
- Head Injury
- Low level of education

- Type 2 Diabetes
- Obesity
- High blood pressure
- Hyperlipidemia
- Cerebrovascular risk

Synergistic interactions
Dementia: Immediate Rule Outs

Masquerading conditions:

- Metabolic conditions
  - Thyroid
  - B12 deficiency
- Alcohol
- Depression
- Sleep apnea
- Delirium
- Medications
  - OTC (Benadryl, sleep aids)

Synergistic interactions
Playing the Odds

• Alzheimer’s Disease (60-80%)
• Vascular Dementia (15-20%)
• Dementia with Lewy Bodies (8-12%)
• Frontotemporal Dementia (5%)
<table>
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<th>What’s the Difference?</th>
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<td><strong>Alzheimer’s Disease</strong></td>
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<td><strong>Prevalence</strong></td>
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<td><strong>Early Symptoms</strong></td>
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<td><strong>Cortical Changes</strong></td>
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<tr>
<td><strong>Course</strong></td>
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<tr>
<td><strong>Associated Factors</strong></td>
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</table>
Progression of Alzheimer’s Disease

- **Presymptomatic**: ~5-20 years
- **Prodromal**: ~1-10 years
- **Mild Cognitive Impairment**: ~2-20 years
- **Dementia**:

Cognitive Function

Years
Prevalence and Culture

- **Latino- vs. Anglo-American**
  - earlier symptom onset (~7 years)

- **African- vs. Anglo-American**
  - 55 - 64 = 3x higher
  - 65 – 84 = 2x higher
  - 85+ = 1.5x higher

- **Japanese- American vs. Japanese**
  - Significantly higher with higher acculturation
Basic Assessment of Dementia

- Interview/History
- Physical exam
- Neurological exam
- Cognitive assessment
- Functional status
- Depression assessment
- Laboratory

- Neuropsychological evaluation
- Neuroimaging

- Repeat if unclear
  - 6-12 months
Assessment: Cognitive Screening

• In primary care settings, only <50% of patients with dementia are diagnosed
  – Critical information for other providers/care team members, esp. if the PCP is unavailable

• Better diagnostic aids are needed
  • Accurate
  • Brief
  • Cost effective

Cognitive Screening - MMSE

- 30 items, 6 domains, 5-10 minutes
- Standard cutoff of 23-24
  - Sensitivity = 66-73%
  - Specificity = 87-92%
  - Positive Predictive Value = 58-67%

- Misclassification rate = 15%

- Age and education effects/norms
  - Sensitivity = 92%
  - Specificity = 96%
Cognitive Screening - MMSE

- SALSA study (MMSE) (Espino et al., 2001 & 2004; JAGS)
  - Internal consistency depends on scoring
  - Education effects
  - Language ability
  - Neighborhood effects
  - Socioeconomic status

- MMSE False Positive Rates
  - 6% for non-impaired majority
  - 42% for non-impaired minority
Cognitive Screening - MMSE

- Improved validity in combination
  - Clock drawing
    - Depends on scoring system
    - Sensitivity = .92 (MCI = .75)

- Several other measures as good, if not better
  - Short Blessed Memory Test & Animals (Kilada et al., 2005)
    - 5-item recall and animal naming
  - Mini-Cog (Borsen et al., 2000)
    - 3-item recall and clock

- Especially true for MCI
Screening: Mini-Cog

- 3-word recall (0-3 points) + Clock (0 or 2 points)
- 2-4 minutes
- Sensitivity = 83%
  - Rule in 13 of 20 possible patients
  - Rule out 18 of 20 healthy patients

Cognitive Assessment
Clock Drawing Test

- Quick office-based assessment tool
- Brief (1-5 minutes)
- Minimal language requirement
- Does not require specialized testing materials
- Easily adapted for non-English-speaking elderly

Screening: MoCA

- Better sensitivity (cutoff = 26, slightly lower in community setting)
  - MCI
    - MMSE = 18%
    - MoCA = 90%
  - AD
    - MMSE = 78%
    - MoCA = 100%

- Specificity
  - MMSE = 100%
  - MoCA = 87%
CLINICAL PROVIDER PRACTICE TOOL

COGNITIVE IMPAIRMENT IDENTIFICATION

**Annual Exam**
- Mini Screen
- Mini-Cog or GDS-15
- Family Questionnaire or GDS-Informant Version

**Tools**
- GDS
- Family Questionnaire

**IF**
- Mini-Cog < 4 OR GDS < 9
- Family Questionnaire > 2 OR GDS-Informant Version ≤ 3

**IF**
- Normal
- Follow up in 1 year

**Cognitive Assessment**
- Same day or new visit + include family

**Tools**
- One of the following: SLUMS, MoCA
- AND Family Questionnaire or GDS-Informant Version

**IF**
- Normal
- Follow up in 1 year

**Score falls outside of normal range**

- **Normal Range:**
  - SLUMS = 77–105 (HS education)
  - MoCA = 26–30 (HS education)
- **Family Questionnaire:**
  - GDS-Informant Version > 3

**Option 1**
- Do complete dementia workup (see Page 2)

**Option 2**
- Refer to: Champion in your practice, neurologist, neuropsychologist**

* A cut point of <2 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.

**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 not beneficial in severe impairment (i.e., MoCA < 12).
Bree Collaborative

Recommendations Available
http://www.breecollaborative.org/topic-areas/alzheimers/
Chair: Kristoffer Rhoads, PhD, Memory and Brain Wellness Center, UW Medicine
Kimiko Domoto-Reilly, MD, Alzheimer's Research Center, UW Medicine
Richard Furlong, MD, Primary Care, Virginia Mason Medical Center
Barak Gaster, MD, Professor of Medicine, UW Medicine
Kelly Green, MSW, Social Worker, Evergreen Health
Debbie Hunter, Family Caregiver
Nancy Isenberg, MD, MPH, FAAN, Neurologist, Virginia Mason Medical Center
Arlene Johnson, Family Caregiver
Kerry Jurges, MD, Primary Care, Confluence Health
Eric Larson, MD, MPH, Vice President for Research and Health Care Innovation, Kaiser Foundation Health Plan of Washington
Todd Larson, Family Caregiver
Myriam Marquez, Patient Advocate
Shirley Newell, MD, Chief Medical Officer, Aegis Living
Darrell Owens, DNP, ARNP, Clinic Chief, Director, University of Washington Outpatient Primary, Palliative and Supportive Care Program
Tatiana Sadak, PhD, ARNP, UW Medicine
Bruce Smith, MD, Medical Director, Regence Blue Shield
Focus Areas

1. Diagnosis
2. Ongoing Care and Support/Management
3. Advance Care Planning and Palliative Care
4. Need for Increased Support and/or Higher Levels of Care
5. Preparing for Potential Hospitalization
6. Screening for Delirium Risk Prior to Surgery
Propose two-step process: initial test and follow-up appointment

**Current State:** Issues with memory and cognition are addressed if they are brought up by the patient or family member(s). The primary care provider may be unsure as to screening tools, Federal or State requirements, or next steps if a patient or family members brings up concerns with memory and not feel comfortable discussing cognitive issues.

**Steps Toward Goal:** Screening for at-risk populations, clear clinical pathway for people who screen positive including through the Medicare Annual Wellness visit.

**Goal for Usual Care:** Healthy adults with mild cognitive impairment (MCI) or dementia are detected at an early stage, targeting early evidence-based interventions. Primary care providers are clear on the value of early detection as well as requirements and feel supported and comfortable truthfully discussing cognitive issues.
Alzheimer’s Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting

Medicare Annual Wellness Visit (HCPCS codes G0438 or G0439)

A  Review HRA (especially reports of functional deficits), clinician observations, and self-reported concerns; and query patient and, if available, informant

Yes  Signs/symptoms of cognitive impairment present

No  No

Informant available to confirm

Yes  Conduct brief structured assessment

No  Follow-up during subsequent AWV

B  Conduct brief structured assessment

Patient Assessment: GPCOG or Mini-Cog or MIS
Informant assessment of patient: AD8 or GPCOG or Short IQCODE

Brief assessment(s) triggers concerns:

Patient: GPCOG ≤5 (5–8 score is indeterminate without informant) or Mini-Cog ≤3 or MIS≤4
Informant: AD8 ≥2 or GPCOG informant score ≤3 with patient score ≤8 or Short IQCODE ≥3.38

Yes  Refer for full dementia evaluation or Conduct full dementia evaluation

If informant is available during AWV can follow up same day as AWV and bill for E/M service with CPT codes 99201-99215. If not, schedule new visit for evaluation and request presence of family/companion to facilitate assessment.

No  Follow-up during subsequent AWV

C  Refer for full dementia evaluation or Conduct full dementia evaluation

* No one tool is recognized as the best brief assessment to determine if a full dementia evaluation is needed. Alternate tools (e.g., MMSE, SLUMS, or MoCA) can be used at the discretion of the clinician. Some providers use multiple brief tools prior to referral or initiation of a full dementia evaluation.

AWV = Annual Wellness Visit; GPCOG = General Practitioner Assessment of Cognition; HRA = Health Risk Assessment; MIS = Memory Impairment Screen; MMSE = Mini Mental Status Exam; MoCA = Montreal Cognitive Assessment; SLUMS = St. Louis University Mental Status Exam; Short IQCODE = short Informant Questionnaire on Cognitive Decline in the Elderly
Cognitive Impairment Care Planning

- **99483 CPT Code (G0505)**
  - Cognition-focused evaluation
  - Medical decision making
    - Moderate or high complexity
  - Functional assessment
  - Decision-making capacity
  - Standardized dementia staging
  - Medication reconciliation and review
  - Evaluation of neuropsychiatric symptoms
  - Evaluation of safety
  - Caregiver assessment
  - Advance care planning
  - Palliative care needs
  - Creation and review of a care plan

- RVU = 6.64
  - Physician work = 3.44
  - CMS average payment = $238.30
Intervention Targets in AD

Cognitive Function

Presymptomatic

MCI

Dementia

Presymptomatic / MCI

Years

gradual accumulation of neuropathology
decrease neuropathology
Prevention and Interventions

- Treatment of Modifiable Risk Factors
  - Cardiovascular
  - Sedentary lifestyle
  - Sleep disorders/disruption
  - Alcohol
- Cardiovascular Exercise
- Cognitive Activation and Rehabilitation
- Dietary Interventions
- Meditation/Mindfulness-Based Stress Reduction
- Community Engagement and Socialization

- Early interdisciplinary involvement
Review

The effect of physical activity on cognitive function in patients with dementia: A meta-analysis of randomized control trials

C. Groot$^{a,b,*}$, A.M. Hooghiemstra$^{a,c}$, P.G.H.M. Raijmakers$^b$, B.N.M. van Berckel$^b$, P. Scheltens$^a$, E.J.A. Scherder$^c$, W.M. van der Flier$^{a,d}$, R. Ossenkoppele$^{a,b}$

<table>
<thead>
<tr>
<th>Study</th>
<th>SMD</th>
<th>CI</th>
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</table>
Exercise training increases size of hippocampus and improves memory


Department of Psychology, University of Pittsburgh, Pittsburgh, PA 15260; Beckman Institute for Advanced Science and Technology, and Department of Kinesiology and Community Health, University of Illinois, Champaign-Urbana, IL 61801; Department of Psychology, University of Illinois, Champaign-Urbana, IL 61820; Department of Psychology, Ohio State University, Columbus, OH 43210; and Department of Psychology, Rice University, Houston, TX 77251
MIND diet associated with reduced incidence of Alzheimer’s disease

Martha Clare Morris\textsuperscript{a,*}, Christy C. Tangney\textsuperscript{b}, Yamin Wang\textsuperscript{a}, Frank M. Sacks\textsuperscript{c}, David A. Bennett\textsuperscript{d,e}, Neelum T. Aggarwal\textsuperscript{d,e}

- \(N = 923\)
- Age 58-98
- 4.5 years
- DASH + Mediterranean
  - One glass of wine
- 53% reduction in incidence
Computerized Cognitive Training in Older Adults With Mild Cognitive Impairment or Dementia: A Systematic Review and Meta-Analysis


Overall Cognitive Outcomes: Mild Cognitive Impairment

<table>
<thead>
<tr>
<th>Study</th>
<th>Hedges’ g (95% CI)</th>
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<td>Kim et al. (66)</td>
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<td>Herrera et al. (56)</td>
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<td>Wiltink et al. (54)</td>
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<td>Tarjan et al. (47)</td>
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<tr>
<td>Gooding et al. (30)</td>
<td>0.68 (–0.07 to 1.43)</td>
<td>4.16</td>
</tr>
<tr>
<td>Hagovsky et al. (45)</td>
<td>0.77 (0.02 to 1.52)</td>
<td>4.11</td>
</tr>
<tr>
<td>Lin et al. (67)</td>
<td>0.65 (0.19 to 1.10)</td>
<td>11.27</td>
</tr>
<tr>
<td>Overall</td>
<td>0.74 (–0.15 to 1.62)</td>
<td>2.99</td>
</tr>
</tbody>
</table>

Tests for heterogeneity: χ² = 15.55, df = 16, p = 0.49, I² = 0
Test for overall random effect: Z = 4.554, p < 0.001

Overall Cognitive Outcomes: Dementia

<table>
<thead>
<tr>
<th>Study</th>
<th>Hedges’ g (95% CI)</th>
<th>Weight (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heiss et al. (58)</td>
<td>–0.01 (–0.65 to 0.64)</td>
<td>10.66</td>
</tr>
<tr>
<td>Tarraga et al. (59)</td>
<td>0.11 (–0.58 to 0.80)</td>
<td>9.96</td>
</tr>
<tr>
<td>Galante et al. (32)</td>
<td>–0.13 (–1.26 to 1.00)</td>
<td>4.50</td>
</tr>
<tr>
<td>Optale et al. (31)</td>
<td>1.00 (0.27 to 1.73)</td>
<td>9.08</td>
</tr>
<tr>
<td>Fernandez-Calo et al. (55)</td>
<td>1.13 (0.38 to 1.89)</td>
<td>8.75</td>
</tr>
<tr>
<td>Boiler et al. (42)</td>
<td>0.02 (–0.92 to 0.96)</td>
<td>6.20</td>
</tr>
<tr>
<td>Boiler et al. (42)</td>
<td>0.16 (–0.78 to 1.10)</td>
<td>6.15</td>
</tr>
<tr>
<td>Man et al. (50)</td>
<td>0.48 (–0.14 to 1.11)</td>
<td>11.40</td>
</tr>
<tr>
<td>Lee et al. (60)</td>
<td>–0.06 (–1.06 to 0.96)</td>
<td>5.38</td>
</tr>
<tr>
<td>Barban et al. (44)</td>
<td>–0.06 (–0.49 to 0.38)</td>
<td>17.50</td>
</tr>
<tr>
<td>Zhuang et al. (33)</td>
<td>0.14 (–0.54 to 0.82)</td>
<td>10.23</td>
</tr>
<tr>
<td>Overall</td>
<td>0.26 (0.01 to 0.52)</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Tests for heterogeneity: χ² = 13.60, df = 10, p = 0.192, I² = 26.48
Test for overall random effect: Z = 2.00, p = 0.045
Meditation and Alzheimer’s

• **Reduction of risk factors**
  - Hypertension (Anderson et al., 2008)
  - Cholesterol (Walton et al., 2004)
  - Depression (Beadreau, 2008)
  - Anxiety (Beadreau, 2008)

• **Improved perfusion** (Newberg et al, 2001)

• **Protected white matter networks** (Pagoni, 2007)

• **Inflammatory modulation** (Luders et al., 2013)

• **Decreased stress hormones** (Jacobs, 2013)

• **Downstream effects**
  - Alcohol?
Meditation and AD

Cognitive Rehabilitation

- Restitution vs. Compensation
- Internal Strategies
  - Encoding
  - Storage
  - Retrieval
- External devices
Palliative Care and Dementia

**Figure 5**

Percentage Changes in Selected Causes of Death (All Ages) Between 2000 and 2014

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>-1%</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>-9%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>-14%</td>
</tr>
<tr>
<td>Stroke</td>
<td>-21%</td>
</tr>
<tr>
<td>HIV</td>
<td>-54%</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>89%</td>
</tr>
</tbody>
</table>

Created from data from the National Center for Health Statistics.208, 219

Palliative Care and Dementia

Integrated Palliative Care Framework

- Disease-Modifying Therapy (curative, or restorative intent)
- Palliative Care
- Hospice
- Bereavement

NHWG. Adapted from work of the Canadian Palliative Care Association and Frank Ferris, MD.
Back to the Basics

• Need to encourage discussion and manage even the **basics** of end of life care
  – Feeding tubes in advanced dementia
  – Advanced directives
    • Issue of capacity
  – POLST
  – DNH (Do Not Hospitalize)
  – Living will
  – Durable Power of Attorney
  – Estate issues
  – Elder law referrals
UW Memory and Brain Wellness

- A consortium of
  - Alzheimer Disease Research Center (NIA)
  - Pacific Northwest Udall Center (NINDS)
  - Memory and Brain Wellness Clinic

- Links state-of-the-art clinical evaluation and care with research programs in Alzheimer’s and related disorders
MBWC – Interdisciplinary Approach

- Neurology
- Geriatrics
- Psychiatry
- Neuropsychology
- Nursing
- Social Work
- Neurogenetics
What Do We Do?

- **Data Gathering visit**
  - VS- full set including weight and SpO₂
  - Physician evaluation
  - Social work consultation

- **Diagnostic tests (MRI, neuropsych, labs, LP, PET, genetic)**

- **Family Visit**
  - Physician feedback
  - ARNP/Social Worker

- **Managed follow up/partnership with PCP**
- **Referrals/Agency Partnerships**
- **Community Engagement**
Resources

- Dementia Action Collaborative/State Plan
  - https://www.dshs.wa.gov/altsa/dementia-action-collaborative
Resources

Dementia Road Map:
A Guide for Family and Care Partners

Dementia Action Collaborative
Washington State
Dementia Road Map: A Guide for Family and Care Partners

Contents:
- Welcome pg. 4
- Wondering & Worried pg. 6
- Mild Cognitive Impairment pg. 8
- Early-Stage Dementia pg. 10
- Mid-Stage Dementia pg. 14
- Late-Stage Dementia pg. 18
- Dementia Quick Reference pg. 21
- Communication Tips pg. 23
- Resources pg. 25
- Action Steps Summary pg. 27

Dementia Road Map Overview:

Wondering & Worried
- Is everything OK?
- Should my loved one be checked by a health care professional?
- What if my loved one won't go to a health care professional?

Mild Cognitive Impairment (MCI)
- Where do we go to get memory loss checked out?
- How can I help my loved one with their memory and thinking?
- What can we do to promote our loved one's well-being?
Early-Stage Dementia

- Are there any medication, treatments or lifestyle changes that could help my loved one’s memory and thinking?
- How can we help our loved one stay active and connected?
- Should my loved one still be driving?
- Is our legal paperwork in order?

Mid-Stage Dementia

- What can I do to make the home safer?
- What do we do if our loved one won’t stop driving?
- Where do we get help in coping with behaviors?
- What services might help and where do I find them?

Late-Stage Dementia

- What can we do to promote quality of life?
- What kind of care is best for my loved one?
- What do we want in terms of medical care at the end of our loved one’s life?
What you can do:

- Learn about normal changes with aging and those that indicate a need to get a check up. See the “10 Warning Signs” on page 21.
- Keep track of changes you notice. If your loved one doesn’t bring it up, find the right time and a sensitive way to discuss these changes with them—get it out in the open.
- Ask your loved one to have a complete medical check-up. It’s important to know if memory and thinking changes may be caused by something that could be treated or reversed. Even if not, it’s best to know what you’re dealing with.
- If your loved one is resistant to a medical check-up, enlist the help of trusted family or friends who may be able to encourage this.
- Call and ask your loved one’s health care professional for the Medicare Annual Wellness exam (if they are on Medicare) that includes detection of cognitive impairment along with other screenings. Feel free to share with the professional what you’ve noticed either in person or in a letter.
- If you don’t feel comfortable with your loved one’s current health care professional, try to find a new one. Most primary care professionals can diagnose dementia. But if you’re looking for a specialist, contact the Alzheimer’s Association to help identify providers in your area.
- If you know or suspect your loved one has hearing loss, get it checked and addressed—hearing loss makes it harder for a person with memory loss or confusion to communicate. This can lead to misunderstandings and social isolation.
- Make sure both you and your loved one are making healthy lifestyle choices:
  - Stay active and engaged in social groups, arts, and other activities of interest.
  - Eat fresh fruits and vegetables.
  - Be physically active.
- Make it a priority to begin and/or complete legal, financial and advance care planning, including essential planning documents. While all adults should have a plan in place in the event of one’s disability or death, such planning is even more important for anyone beginning to experience changes in memory or thinking abilities. While such changes may or may not end up being dementia, it is critical to complete this planning while your loved one has the ability to do so.

Action Steps

The following steps are important at this point:

- Obtain a medical assessment to find out what may be causing the problems.
- Complete health care planning documents. Your loved one should have:
  - A Health Care Directive (also called a “living will” or “advance directive” regarding treatment preferences); and
  - A Durable Power of Attorney for Health Care, appointing a health care “agent.”
- Complete a General Durable Power of Attorney document. In this document, your loved one appoints an “agent” to assist with financial and related matters.
- Complete an estate plan. Your loved one’s estate plan may include legal documents such as a will or a trust that direct the disposition of their estate upon death.
- Have a family meeting to discuss what’s happening, and necessary next steps.
Resources Mentioned in the Document

ORGANIZATIONAL WEBSITES

- Aging Life Care Association (for private geriatric care management services): www.aginglifecare.org
- Alzheimer’s Association: www.alz.org or 800-272-3900
- Alzheimer’s Association Washington State Chapter, Serving Washington and Northern Idaho: www.alzwa.org or 800-272-3900
- Alzheimer Society of Washington (Whatcom County): www.alzsociety.org or 360-671-3316 or 800-493-3959
- Alzheimers.org: www.alzheimers.gov
- Community Living Connections (Area Agencies on Aging/AAAs): www.waclc.org/connect or 855-567-0252
- Eldercare Locator (Administration on Aging): www.eldercare.gov or 800-677-1116

INFORMATION AND DOCUMENTS

- At the Crossroads: Family Conversations about Alzheimer’s, Dementia and Driving: www.hartfordauto.thehartford.com/UI/Downloads/Crossroads.pdf
- Communication: Tips for Successful Communication During All Stages of Alzheimer’s Disease: www.alz.org/national/documents/brochure_communication.pdf
- Dementia and Driving Issues: www.alz.org/care/alzheimers-dementia-and-driving.asp
- Living Well with MCI or Early Dementia: www.alz.org/documents/mndak/alz_living_well_workbook_2011v2_web.pdf
- MedicAlert+Safe Return: www.alz.org/care/dementia-medical-alert-safe-return.asp or 888-413-3768
- Safety Concerns for People with Dementia—An Info Kit: go.usa.gov/x5ESt or by visiting www.dshs.wa.gov/altsa/dementia-action-collaborative
Resources

- Alzheimer Society of WA (HEAD Talks)
  - https://alzsociety.org/

- Alzheimer’s Association (www.alz.org)
  - Taking Action workbook:
  - Living Well workbook:

- Momentia Seattle (www.momentiaSeattle.org)

- Areas on Aging (http://www.agingwashington.org)
Resources - Driving

 pháy the image of a website page titled "Senior Driving". The page features various sections including:

- Know the Licensing Laws in Your State
- Smart Features for Older Drivers
- Does Your Car Fit You?
- Roadwise Rx
- Take a Refresher Course
- Ask the Experts
- Attend a Senior Driving Expo

Each section provides information or resources related to driving for seniors.
Community Resources

- AAA (www.seniordriving.aaa.com)
Future Directions

• GIM Integration
  • MBWC-Primary Care Liaison Team
  • Annual Medicare Wellness Visit
  • Neighborhood Clinics

• Group interventions for MCI/early dementia
  • ADAPT
  • Dementia-friendly Intergenerational Arts
  • Exercise
  • MBSR

• Outcome Measurement
  • Dementia Performance Measurement Set (AAN, 2011)
Thank you for your attention!

Questions?
Contact Information

Memory and Brain Wellness Center
https://depts.washington.edu/mbwc/
Harborview Medical Center
325 9th Ave., 3rd Floor West Clinic
Seattle, WA 98104
Phone 206-744-3045
Fax 206-744-8527
krhoads@uw.edu
References/Resources


References/Resources