National ECHO Care of the Elderly: Mental Health

Session 4: Assessment, Diagnosis and Management of Dementia

Disclaimer: All information is provided by healthcare providers working in Canada in the area of mental health of older adults. All identifying information including names of individuals, organizations, or locations have been removed for privacy.

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Question 1: Do you have any experience with RUDAS?

Answer: RUDAS is another cognitive screening test. I use the RUDAS where someone may have very limited education or English as a second language. It's a test that's a bit easier. It's not ideal but sometimes you have a family member who's translating for you. The RUDAS is a very good tool for that because the instructions are pretty clear. If you have to use a translation service, that's often where I'll use the RUDAS. I would say the RUDAS in my experience, the total scores on it, tend to light up a little bit more like the Mini Mental. It's an easier test than SLUMS or MoCA, but it can be very helpful. That's typically when I would use it, limited education or English as a second language because I do find it's a bit easier to work with in terms of translation. Culturally, it's a little less biased. There is no copyright from what I understand so it's one of the ones that's on the list that can be used freely. I don't think there's any plan to copyright it either.

Question 2: If you don't screen for cognitive impairment, how do you differentiate between patients that have the insight to know that there was a change and those that don't, especially patients with no family or friends to tell them or advocate for them? In my experience, most patients will downplay cognitive changes or deny them stating that they are part of regular aging.

Answer: It's really challenging. As a specialist, I see people who are being referred by a family doctor or a primary care clinician. I think as a primary care clinician, if you're involved with someone longitudinally, you're actually not in a bad place to pick up on some of these changes such as forgetting appointments, medications not being refilled, and being vague with their history with you when they're coming in for visits. Those might be functional red flags based on your assessment of the individual or your interactions with them. It is really hard if you don't have a good source of collateral history. If you have a homecare assessment on someone, where you're questioning how they're functioning at home, that can be very insightful. It can be really challenging if you don't have good collateral history available to you. The testing on its own can be quite informative. Below a certain level, the cognitive exam tests are really abnormal in everyone and that can also be helpful. It's not necessarily diagnostic, but if I see a MoCA of 15, regardless of how the person thinks they're doing there's probably something going on that needs a further look.

Question 3: Does anyone else have any tips or tricks that they use in this situation, maybe people who are primary care NPs or family docs? How do you approach this issue with the person who doesn't even want to approach it and states that this is just the normal thing that their parents went through and that they're going through? Anyone else have any thoughts about this or tips that they could share?

Answer: It's challenging in primary care especially for NPs who may not see the patient regularly or know them. I tend to ask about car accidents or where family allows them to drive their grandkids. The grandkids question is a very common one for sure.

I think asking the family about changes that one can be concerned about with caring and safety. Finding out about the individual and if that individuality has changed from the family's perspective. That way, I think you can help to persuade the patient that there's some meaning to doing this and they don't feel that it's a judgment issue.

Did they lose weight? Looking for more objective measurements that you could present to the patient and say, "Look what's happening here, you're also losing weight?" Maybe we should be looking for something else.

If you cannot do it in one session, approach it and lay it out there. Another session, another visit, and maybe dive in a little bit and do a Mini-Cog perhaps. Sometimes just building that trust with the patient or focusing on something else and tying the memory in with another medical condition.

It's building trust, of going very slowly and progressively and not feeling like you have to do it all at once. I have the luxury with 30 years of practice so I can say, "I've known you for a long time now and I know that things have been changing but this seems a little off course. It seems like there's something here and that's my perspective. Yours doesn't always agree but why don't we look at this a little bit further. Would that be okay?" I do feel for people who have to gain that trust quickly when trust is something that in all of our other relationships doesn't happen overnight. I don't know why we would expect that this would happen necessarily in professional clinical relationships overnight.

I work at a community health center. We have a dietician and an occupational therapist and a pharmacist and oftentimes people are involved with more than one practitioner. Maybe they have a trusting relationship with somebody else that they're willing to engage with about the discussion.

Question 4: Are there new guideline recommendations for cholinesterase inhibitors for vascular dementia?

Answer: They are Health Canada approved. They do have some evidence in vascular dementia. One of the challenges with vascular dementia is it can mean a whole bunch of things. If you had a single large stroke in the frontal part of your brain which may not affect the memory pathways at all, a cholinesterase inhibitor may not be that helpful. If it is more of a multi-infarct dementia that doesn't tend to involve more memory pathways, the evidence is that while they are modestly effective in Alzheimer's, they are probably less effective in vascular dementia. In mixed dementia there does seem to be a bit of evidence as well and though there is not much evidence there is some. Most people with

vascular dementia have some degree of Alzheimer's as well. That would be the most common scenario and it's hard to tease those apart.

Question 5: My question is the one off visit to the geriatrician where a client or a patient is assessed for dementia. Are they incorporating all of the evidence or should it be over two or three visits over a year, year and half, two years so that we can see a decline versus some other factor?

Answer: As a specialist I can speak to that. One of the differences I would say is that we often have an hour, hour and a half for our assessments which is quite different than primary care. I think the part of doing it over time can help ease into it in terms of managing what can be a fairly lengthy assessment. The benefit for me is often there is a wait list to see me so often a family doctor did a MoCA. They are waiting six months to see me and I am doing another MoCA so I have a longitudinal assessment built into our waitlist. I will often see people longitudinally if they have MCI or it's unclear. I may need more investigations or a repeat evaluation so it is not uncommon for me to say, "Let's get an MRI, maybe we will get neuropsychology, or maybe I will just bring you back and repeat the testing in six months and re-review the functioning of cognition." It depends. We do have the luxury in specialty clinics of longer appointments which can help and a lot of the background work has already been done, in terms of the investigations and often some screening, by primary care

Question 6: Can you speak to the idea of virtual cognitive assessment and what you would recommend particularly with some of the issues around the MoCA requiring certification now?

Answer: In my own clinics, if I am doing virtual assessments, I will do a MoCA on Zoom including the screen sharing. If you can't do the MoCA by Zoom, you can do the SLUMS by Zoom. You do have to show the figures, get them to do the drawing part of it, and then show you the drawing, but that can be done by Zoom. There is also a verbal MoCA which submits the visual sections. There are verbal forms of the MMSE but in my practice I use a telephone MoCA if they just have a phone or I will use a regular MoCA or SLUMS if I am doing it by assessment. If I do need a more detailed assessment than that I am often trying to arrange for someone to come in when it is safe to do so for a clinic visit or if I need a more in depth neurological exam because there are some limitations to virtual assessments.

The Canadian Association of Geriatric Psychiatry is going to be compiling a list.

The CCNA, The Canadian Consortium on Neurodegeneration in Aging has a working group during COVID on this and have compiled some validated tools as well.