COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

2.7 PARAMETERS FOR ASSESSMENT OF CO-OCCURRING MENTAL HEALTH DISORDERS & COGNITIVE IMPAIRMENT

May 29, 2013

I. General Parameters: These parameters apply to individuals at risk for co-occurring cognitive impairment (CCI).

A. DMH clients should be screened for co-occurring cognitive impairment (CCI) including screening for specific symptoms of CCI.

B. DMH clients who are older adults (OA) (60 years of age or older) should receive relatively more extensive assessment for CCI, as they are at higher risk for these conditions.

C. Adults at risk for CCI or dementia based on family history, head trauma, environmental exposures, infectious, cardiovascular, and other disease states should have an extensive evaluation.

D. Any one of the following observed signs and/or symptoms by clinician, family or community should initiate an assessment of cognitive function:

1. Memory impairment;

2. Functional impairment; (Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs);

3. Change of personality or behavior;

4. Loss of executive function (judgment);

5. Loss of language skills;

6. Loss of motor function

E. When screening indicates presence of cognitive impairment (CI), a differential diagnosis should include delirium, dementia, and/or CI due to specific psychiatric disorders and/or abuse.

F. When symptoms of cognitive disorder are noted, an initial screening for general medical conditions and substances that may cause that disorder should be completed.

1. An initial screening for general medical conditions that may be causing and/or contributing to CCI should include a thorough medical history, review of systems, medication review and appropriate laboratory tests.

2. Screening for substance abuse should include third party history and appropriate screening tools. (Appendix)

G. An assessment of the severity (mild, moderate, severe), duration, and course of cognitive decline should determine the intensity and speed of further assessment and intervention.

H. OA, dependent adults, and children with suspected CI should be assessed for abuse (physical, sexual, financial, and emotional) and neglect, as CI in these groups confers special vulnerability to such acts.

I. Screening should include assessment for presence of domestic violence.

J. Screening should include efforts to detect the use of specific evidenced-based tools to detect CI. (Appendix)

II. Procedures for Assessment

A. General procedures for assessment should include the following:

1. Interviewing techniques that accommodate impaired hearing, vision, cultural issues, physical limitations, language barriers, education modesty and stamina. i.e., clear simple communication, and

2. Appropriate consenting procedures.

B. History should include the following:

1. A comprehensive medical, surgical and psychiatric history obtained from the most reliable sources;

2. A comprehensive medication evaluation which should include documentation of:

a. All medications prescribed from each provider;

b. Medication response including previous trials and outcomes;

c. Medication adherence;

d. Alternative and complementary medicine;

e. Other people's medication ("OPMs");

f. Recent changes in medication (i.e. dose, formulations, and mode of administration);

g. Current use of benzodiazepines, opioids and anticholinergic medication, which should be avoided and, if used, carefully monitored;

3. Current or past high risk sexual behaviors e.g. risk of Human Immunovirus, or neurosyphillis;

4. Recent of past falls or head trauma;

5. A chronology and details of any changes in cognition, personality, behavior, function, mood or social habits. Associated circumstances and input from both the patient and reliable sources should be included;

6. Social history including an evaluation of current social contact(s) and change in quality and number.

C. A comprehensive review of present symptoms should be obtained from the most reliable source. (See list of review of symptoms.)

1. A review of medical records should include results of most recent complete:

a. Physical exam,

b. Laboratory results,

c. EKG, and

d. Imaging studies.

D. A comprehensive screening of any of the following may include as indicated:

1. Cognition:

a. Mini-Mental Status Exam (MMSE);

(A screening MMSE should be administered on all OA Full-Service Partnership, OA Field Capable Clinical Services, and OA Prevention and Early Intervention patients 60 and over during the initial assessment, at the annual reassessment and when clinically indicated.)

b. MiniCog; (Appendix)

c. MoCA (Appendix) MoCA should be administered for screening:

i. Suspected Dementia either missed by the MMSE score of 24-30 and/or Mini-Cog **(**normal clock, and memory score of 1 to 3); or

ii. Mild Cognitive Impairment (MCI)**.** The MoCA may be used as the only cognitive screening tool for MCI without associated functional impairment.

2. Judgment: Clock Drawing Test (as part of Minicog);

3. Function:

    a. Evaluation of ADLs/IADLS as reported by both patient and observer (Appendix);

    b. Screening of gait or transfer (using a tool such as the “get up and go”); If limited mobility then assess for adequate supervision. (Appendix)

    c. Screening of hearing (rustling fingers or whisper test; (Appendix)

    d. Screening of vision screen (Snellen or read newsprint); (Appendix).

4. Mood;

    a. Geriatric Depression Scale; (Appendix)

    b. PHQ (Appendix)

5. Substance abuse;

    a. CAGE; (Appendix)

    b. AUDIT; (Appendix)

    c. MAST-G (Appendix)

6. Pain: Pain scale;

7. Safety; A thorough safety screening including:

    a. Home environment with attention to security, fire hazards, risks for trips and falls, unsanitary conditions, presence of hazardous materials, inadequate ambient temperature and ventilation, infestation, etc.;

    b. Hoarding: NSGCD Clutter Hoarding Scale; (Appendix 2)

    c. Risk of wandering and use of medical identification (ID) device;

    d. Risk of abuse including financial, physical, sexual, emotional; (see DMH policy 202.9 Reporting Suspected Elder/Dependent Adult Abuse and Neglect);

    e. Risk for impaired driving ;(Appendix 2)

    f. An evaluation of danger to self and others; Risk for suicidality can be assessed using a tool such as the Litieri Scale. (Appendix 1)

g. An evaluation of evidence and degree of neglect including attention to hygiene, nutrition (weight), hydration, inappropriate clothing, incontinence, etc.;

h. Measurement of respiratory rate, blood glucose, blood pressure & pulse to screen for urgent medical conditions.

8. Consideration of neuropsychiatric testing or referral for further neuromedical work-up;

9. Depth of neurological and medical assessment prior to referral should be consistent with the clinical scope and training of the assessor;

10. Diagnostic assessment should include an explicit identification of each co-occurring disorder, a description of treatment goals for each disorder, and the manner in which these diagnoses and goals determine treatment;

Appendix: Internet References of Documents and Forms

A. Cognition

1. A Guide to Dementia Diagnosis and Treatment": Includes MMSE (copy-written), Minicog and MoCA tools and scoring information. http://dementia.americangeriatrics.org/

2. MoCA Includes MoCA tool, scoring and non-English http://www.mocatest.org/

3. MMSE which is available at all DMH Clinics and Contract Agencies www4.parinc.com

B. Assessment for Capacity for Medical Decision Making (Complete Forms CG 335 and CG335A both of which are required by County of Los Angeles (COLA), Department of Mental Health Office of the Public Guardian and County Counsel for filing petition)

1. http://www.courtinfo.ca.gov/forms/documents/gc335.pdf

2. http://www.courtinfo.ca.gov/forms/documents/gc335a.pdf

C. Screening of Depression

1. GDS short form, long form and foreign languages. www.stanford.edu/~yesavage/GDS.html

2. PHQ-9 http://impact-uw.org/tools/phq9.html (available in English and other languages)

D. Screening for Alcohol Abuse
CAGE, AUDIT, MAST-G, www.samhsa.gov "Alcohol Use among Older Adults"

E. Pain Scale http://www.nccn.org/patients/patient gls/english/pain/2assessment.asp

F. Hoarding Scale
http://www.nsgcd.org/resources/clutterhoardingscale/nsgcd_clutterhoardingscale.pdf

G. Driving

1. Talk with Older Drivers www.theHartford.com/talkwitholderdrivers

2. Mandated Reporting to the California Department of Public Health who reports to the State of California Department of Motor Vehicles (DMV) http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph110c.pdf

H. California Alzheimer's Association – Guideline for Treatment of Dementia
http://www.caalz.org/PDF_files/Guideline-OnePage-CA.pdf

I. Best Practices in Nursing Care to Older Adults. Hartford Institute for Geriatric Nursing. http://www.hartfordign.org/trythis

J. Delirium Screening Tool CAM http://www.americangeriatrics.org

K. Littieri Suicide Screening Tool (Genesis Screening and Assessment Tools)
The Older Adult Geriatric Field Screening Protocol / 01-05-09

L. Geriatric Field Screening Protocol (Genesis Screening and Assessment Tools)
The Older Adult Geriatric Field Screening Protocol / 01-05-09

M. Older Adult Nursing Assessment Form (Genesis Screening and Assessment Tools)
The Nursing Older Adult Assessment Form / 01-05-09