MEMORY ASSESSMENT SERVICES

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- Assessments in Community

- Checks
- TICS-M
- MOCA BLIND
- ACE-III REMOTE
- PILOT STUDY: RESULTS AND CONSCLUSIONS

- Assessments in Care Homes

- Pre-planning
- Offering virtual assessments
- Capacity/ confidentiality

DATA on ASSESSMENTS

- March (post covid)- 112 f2f, 400 virtual
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COMMUNITY

REMOTE MEMORY ASSESSMENTS GUIDANCE

Rajesh Abraham, Phil Slack, Damien Dewhurst, Sophie Monaghan & Sarah Agnew

FORGET screening tool for dementia in community and acute hospitals

FORGET

History from patient/ carer (specify): ----------

(A score of 3+ will need assessment by liaison mental health team for dementia; less than 3 is indicative of delirium; A score of 1+ will need further assessment in Memory Clinic)

Name:	**D.O.B:**
Name of the carer who provides history	
Item **(Should be present at least 6 months)**	**Present=1** **Absent=0**
• **FORGET**	
• **F**amily/ friends recognition	
• **O**dd beliefs or **O**ut of character behaviours	
• **R**epetitive or reduced speech	
• **G**rooming difficulties	
• **E**vening confusion and sleeplessness	
• **T**oilet awareness	
Total Score © Badrakalimuthu VR May 2014	

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The **FORGET tool**

A **screening tool** developed to facilitate use by healthcare professionals in hospital and across the community setting will need to focus on duration of functional impairments and common symptoms of **dementia**. The **FORGET screening tool** consists of seven- items, and takes about 5–7 minutes to administer.

27 Jul 2017

https://www.gmjournal.co.uk › forg...

Forget: a screening tool for dementia | GM

Checks whilst organising remote assessments

- Language and cultural factors.
- Availability of emotional and social support to process a diagnosis of dementia.
- Consent to assess and an understanding of the differences in how they will be assessed, the potential outcomes and how they may receive a diagnosis of dementia.
- Sensory impairments.
- Presence of a family member or carer.
- Availability of a calm environment

Telephone Interview for Cognitive Status

hiatry, Neuropsychology, and Behavioral Neurology
. 2, pp. 103–110
aven Press, Ltd., New York

Detection of Dementia in the Elderly Using Telephone Screening of Cognitive Status

Kathleen A. Welsh, Ph.D., John C. S. Breitner, M.D., M.P.H., and Kathryn M. Magruder-Habib, Ph.D., M.P.H.

The Joseph and Kathleen Bryan Alzheimer's Disease Research Center and Department of Psychia
Duke University Medical Center, Durham, North Carolina, U.S.A.

Summary: Detection of dementia in large, geographically dispersed populations is difficult. Conventional in-person neuropsychological assessment techniques, no matter how brief, are too costly to be practical for this purpose. Telephone interviewing is an obvious alternative for cognitive screening, but its practical utility is relatively unexplored. We therefore investigated the performance characteristics of a telephone screen for dementia in elderly residents of congregate housing facilities. We interviewed 209 subjects using the Telephone Interview for Cognitive Status (TICS) and a modified version (TICS-m) that includes items sensitive to early dementia (delayed recall) and eliminates other items difficult to verify in survey work. After the subjects received a brief in-person neuropsychological assessment, TICS and TICS-m scores were compared as predictors of the resulting clinical assignment (normal, mildly impaired, or demented). Although the TICS-m yielded slightly better results, both versions of the instrument were sensitive and specific indicators of dementia in this community sample. In a separate exercise, both instruments also correctly identified 17 clinic patients with carefully diagnosed Probable AD. Telephone interviewing of cognitive function may therefore provide an economical approach to mental status screening in research studies where in-person assessment is impractical. **Key Words:** Telephone interview—Alzheimer's disease—In-person evaluation—Post hoc scores—Cognitive deficits.
NNBN 6:103–110, 1993

TICS

TABLE 2. *Items of the TICS and the TICS-m*

TICS	Score (points)	TICS-m	Score (points)
1. State full name	2	1. State full name	2
2. Date	5	2. Date	5
3. **State address**	**5**	3. **State age/phone no.**	**2**
4. Counting backward	2	4. Counting backward	2
5. Word list learning	10	5. Word list learning	10
6. Subtractions	5	6. Subtractions	5
7. Responsive naming	4	7. Responsive naming	4
8. Repetition	2	8. Repetition	2
9. **President's last name**	**1**	9. **President's full name**	**2**
Vice Pres. last name	**1**	**Vice Pres. full name**	**2**
10. Finger tapping	2	10. Finger tapping	2
11. Word opposites	2	11. Word opposites	2
		12. **Delayed recall**	**10**
Total	41 pts	*Total*	50 pts

Items unique to either the TICS or TICS-m are in bold type. All other items are identical in the two versions of the telephone interview.

Telephone Interview for Cognitive Status

- TICS-M outcomes:
  - MCI (score of 28-31*)
  - likely dementia (score below 28*)
  - no evidence of dementia (score above 31*)

- *David S. Knopman,Rosebud O. RobertsYonas E. Geda,V. Shane Pankratz, Teresa J.H. Christianson,Ronald C. Petersen,and Walter A. Rocca· Validation of the Telephone Interview for Cognitive Status-modified in Subjects with Normal Cognition, Mild Cognitive Impairment, or Dementia_2010 Jan; 34(1): 34–42*

MOCA-BLIND

MONTREAL COGNITIVE ASSESSMENT / MoCA-BLIND
Version 7.1 Original Version

Name:
Education:
Sex:
Date of birth:
Date:

MEMORY		FACE	VELVET	CHURCH	DAISY	RED	**POINTS**
Read list of words, subject must repeat them. Do 2 trials even if 1st trial is successful. Do a recall after 5 minutes.	1st trial						No points
	2nd trial						
ATTENTION							
Read list of digits (1 digit/sec.) Subject has to repeat them in the forward order [ ] 2 1 8 5 4							
Subject has to repeat them in the backward order [ ] 7 4 2							___/ 2
Read list of letters. The subject must tap with his hand at each letter A. No point if ≥ 2 errors							
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B							___/ 1
Serial 7 subtraction starting at 100							
[ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65							
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**							___/ 3
LANGUAGE							
Repeat: I only know that John is the one to help today. [ ]							
The cat always hid under the couch when dogs were in the room. [ ]							___/ 2
Fluency / Name maximum number of words in one minute that begin with the letter F.							
[ ] _____ (N ≥ 11 words)							___/ 1
ABSTRACTION							
Similarity between e.g. banana - orange = fruit [ ] train - bicycle							
[ ] watch - ruler							___/ 2
DELAYED RECALL	Has to recall words **With no cue**	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						___/ 5
	Multiple choice cue						
ORIENTATION	[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City						___/ 6

© Z. Nasreddine MD **www.mocatest.org** Normal ≥ 18 / 22

TOTAL ___/ 22
Add 1 point if ≤ 12 yr edu

Administered by: _____

MOCA BLIND Study

Telephone Assessment of Cognition After Transient Ischemic Attack and Stroke

Modified Telephone Interview of Cognitive Status and Telephone Montreal Cognitive Assessment Versus Face-to-Face Montreal Cognitive Assessment and Neuropsychological Battery

Sarah T. Pendlebury, MRCP, DPhil; Sarah J.V. Welch, RGN; Fiona C. Cuthbertson, BSc; Jose Mariz, MD; Ziyah Mehta, DPhil; Peter M. Rothwell, FRCP, FMedSci

Background and Purpose—Face-to-face cognitive testing is not always possible in large studies. Therefore, we assessed the telephone Montreal Cognitive Assessment (T-MoCA: MoCA items not requiring pencil and paper or visual stimulus) and the modified Telephone Interview of Cognitive Status (TICSm) against face-to-face cognitive tests in patients with transient ischemic attack (TIA) or stroke.

Methods—In a population-based study, consecutive community-dwelling patients underwent the MoCA and neuropsychological battery >1 year after TIA or stroke, followed by T-MoCA (22 points) and TICSm (39 points) at least 1 month later. Mild cognitive impairment (MCI) was diagnosed using modified Petersen criteria and the area under the receiver-operating characteristic curve (AUC) determined for T-MoCA and TICSm.

Results—Ninety-one nondemented subjects completed neuropsychological testing (mean±SD age, 72.9±11.6 years; 54 males; stroke 49%) and 73 had telephone follow-up. MoCA subtest scores for repetition, abstraction, and verbal fluency were significantly worse ($P<0.02$) by telephone than during face-to-face testing. Reliability of diagnosis for MCI (AUC) were T-MoCA of 0.75 (95% confidence interval [CI], 0.63–0.87) and TICSm of 0.79 (95% CI, 0.68–0.90) vs face-to-face MoCA of 0.85 (95% CI, 0.76–0.94). Optimal cutoffs were 18 to 19 for T-MoCA and 24 to 25 for TICSm. Reliability of diagnosis for MCI (AUC) was greater when only multi-domain impairment was considered (T-MoCA=0.85; 95% CI, 0.75–0.96 and TICSm=0.83, 95% CI, 0.70–0.96) vs face-to-face MoCA=0.87; 95% CI, 0.76–0.97).

Conclusions—Both T-MoCA and TICSm are feasible and valid telephone tests of cognition after TIA and stroke but perform better in detecting multi-domain vs single-domain impairment. However, T-MoCA is limited in its ability to assess visuoexecutive and complex language tasks compared with face-to-face MoCA. **(*Stroke*. 2013;44:227-229.)**

ACE –III Remote Administration

- https://www.sydney.edu.au/brain-mind/resources-for-clinicians/dementia-test.html
- Ensure the carer will be with the participant during the testing/ carer not to provide help or prompts.
- If the participant requires glasses and/or hearing aids, remind the carer to prepare these. The participant should be seated comfortably at a table with clear view of the screen.
- Check with the carer before beginning the test where they are.
- Ensure the carer has the required materials: 1) One pencil 2) 4 blank sheets of paper.
- *ACE-III has not been validated as an online assessment.*

Criteria for neuropsychological assessment

- Subjective/informant complaint of memory problems in the absence of identified cognitive impairment on the TICS-M.
- MCI
- Denoting dementia subtypes
- Risk factors such as placement breakdown or challenging behaviour
- Young onset
- Potential benefit of psychological intervention to promote memory enhancing strategies/neuro rehabilitation

Prescribing Cognitive Enhancers

- Checks for pule rate (ACh I)
- Renal Function Tests (Memantine)
- Scan and e-mail prescriptions
- Piloting e-prescribing in the community

Post-Diagnostic Support

- Telephone support
- TEAMS/ Attend Anywhere Meetings

PILOT OF AA (ATTEND ANYWHERE) AND OTHER REMOTE ASSESSMENTS

Rajesh Abraham & Phil Slack, Consultants in Old Age Psychiatry
Surrey & Borders Partnership NHS Foundation Trust

Results of the pilot of AA (Attend Anywhere) and other remote assessments (1)

- A total of 70 consultations were included in the pilot for Surrey Heath CMHTOP and G&W CMHTOP.
- All included patients were offered virtual consultations using AA platform.
- About 62% of the patient agreed for virtual consultation, 14 % declined and 17% did not have access to appropriate technology including smartphone, tablets, laptops etc.
- Of the 43 patients who agreed to use virtual consultations 40 agreed to use AA.

Results of the pilot of AA (Attend Anywhere) and other remote assessments (2)

- Out of the 40 AA consultations 26 (65%) were successful and 14(35%) were unsuccessful.
- 60 (86%) of the patients did not require further face-to-face and 10 (14%) needed further contact to establish working diagnosis and management plans.
- Remote memory assessments including Remote ACE III and MOCA were successfully completed in 13 (33%) patients using AA.
- AA platform was down for 5 days during this period and these consultations were converted to telephone consultations.

Conclusions from the pilot of AA (Attend Anywhere) and other remote assessments

- AA platform works well if there is good connectivity and can be used as a part of hybrid solution to offer remote assessments for both new patients and reviews.
- Cognitive assessments including remote ACE III are possible over AA if connectivity is good.
- Contingency plans to fall back on telephone consultation should be in place in case of failure of the platform/ connectivity issues etc.
- Remote assessments significantly reduced the need for face-to-face consultations especially in review consultations saving travelling time and associated costs

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CARE HOMES

GUIDANCE FOR REMOTE ASSESSMENTS IN CARE HOMES

Katy Lee, Gareth O'Leary, Georgia Belam & Cathie Sammon

Pre-planning and information gathering

- Triage and review notes on referral.
- Can further collateral history be gathered from carers and family?
- Consider relevant questionnaires and self/carer assessment, including those which can be completed prior to consultation:
  - *Cognition (e.g. Tics-M is recommended within the memory assessment protocol but also consider BLIND MoCA, ACE III, mini-ACE etc)*
  - *Behaviour and Function (e.g. ABC charts, BADLs, Neuropsychiatric Inventory, Challenging Behaviour Scale)*
  - *History (e.g. IQCODE)*
  - *Mood (e.g. GDS, Cornell Scale)*

- Remote consultation to be offered as the main intervention (please see later section for the process to be followed if a face-to-face visit is being considered).

Offering virtual assessment and consultation

- What technology is available? Telephone versus video conference.
- SABP's preferred virtual assessment tool is Attend Anywhere. For meetings, the preferred platform is Microsoft Teams (with care home staff/external stakeholders dialling into the meeting, rather than being invited via email).
  - *If Attend Anywhere or Microsoft Teams are unavailable, alternative virtual tools need to be agreed with senior clinicians and Digital before they are used.*
- Maintain principles of information governance and confidentiality.
  - *NHSX states consent is implied by joining virtual/remote consultation.*
  - *Identify environments for assessment that will maintain confidentiality.*
- Any virtual observations of the person's behaviour in a care home should be first discussed with a senior clinician in the team before they are carried out.
- For the time-being, virtual observations of personal/intimate care should not be completed.

Identity and safeguarding, consent and capacity, confidentiality

- Ensure relevant consent and capacity have been considered and recorded in the appropriate care record.
- Where capacity is lacking, consider the principles of the Mental Capacity Act:
-
  - *Is it in the best interests of the patient to proceed?*
  - *Have Appointees, Deputies or Attorneys been identified and consent sought?*
  - *Have next-of-kin or other relevant persons been contacted where it is deemed in the patient's best interest?*
- Ensure that identities of all participants are confirmed at start of consultation (e.g. requesting personal demographic information).
- Ensure any personal information stored on your device, or obtained through a video or telephone conversation, is safely transferred to the appropriate health and care record as soon as possible.
- Delete any personal information, including back-up data, from your own device.
- Apply Caldicott principles and your own relevant professional standards, as you would normally.

Care Home Pathway Support

Understanding distressed behaviour in dementia: https://youtu.be/6bCFA14cMbk

De-escalation skills in dementia care: https://youtu.be/bJAiW52hnGE

Supporting people with dementia in medical isolation: https://youtu.be/ViYrMDmWbTQ

To find out more about the training, contact: Dr Katy Lee, Intensive Support Team Lead and Principal Clinical Psychologist for Older People at: Katy.Lee@sabp.nhs.uk

QUESTIONS