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Medicare Mental Health Workforce Coalition

Normal Cognitive Aging and Dementia: What Counselors and MFTs Need to Know

June 20, 2024

Sponsored by the Medicare Mental Health Workforce Coalition

Meeting Details

1. **Closed Captioning** is enabled and attendees can turn CC on or off as they desire.

2. **Interpreter Phone Number: 305-224-1968** **Webinar ID: 843 6298 2022** **Passcode: 491432**

3. **Session Evaluation** / **Take Our Evaluation Survey** (CE credit for live attendance only)

4. Webinar will be posted on NBCC website a few days following the webinar.

5. **Q&A:** Please add your questions in the Q&A box at any time during the meeting.

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Suzanne Musil

Suzanne Musil, PhD, ABPP-CN, is a board-certified clinical neuropsychologist in the Memory Care Program at MyMichigan Health in Midland, Michigan. Throughout her career, she has specialized in working with older adults, with expertise in the differential diagnosis of normal aging versus dementia and dementia-related conditions.

Dr. Musil is frequently asked to speak on this topic and enjoys educating patients, family members, and health care professionals on topics related to cognitive aging.

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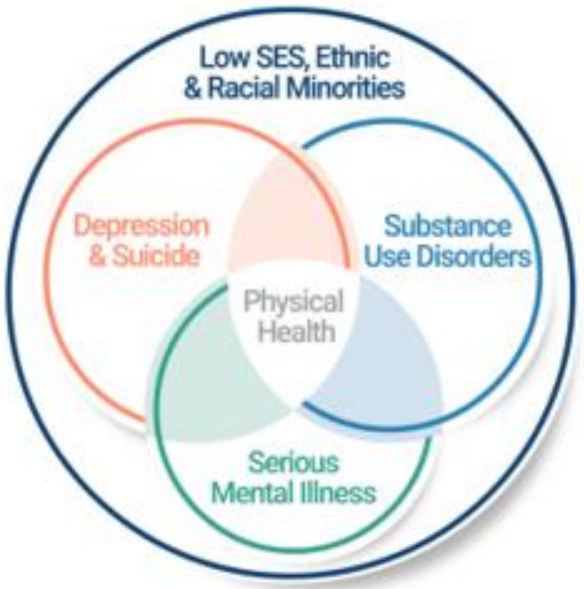

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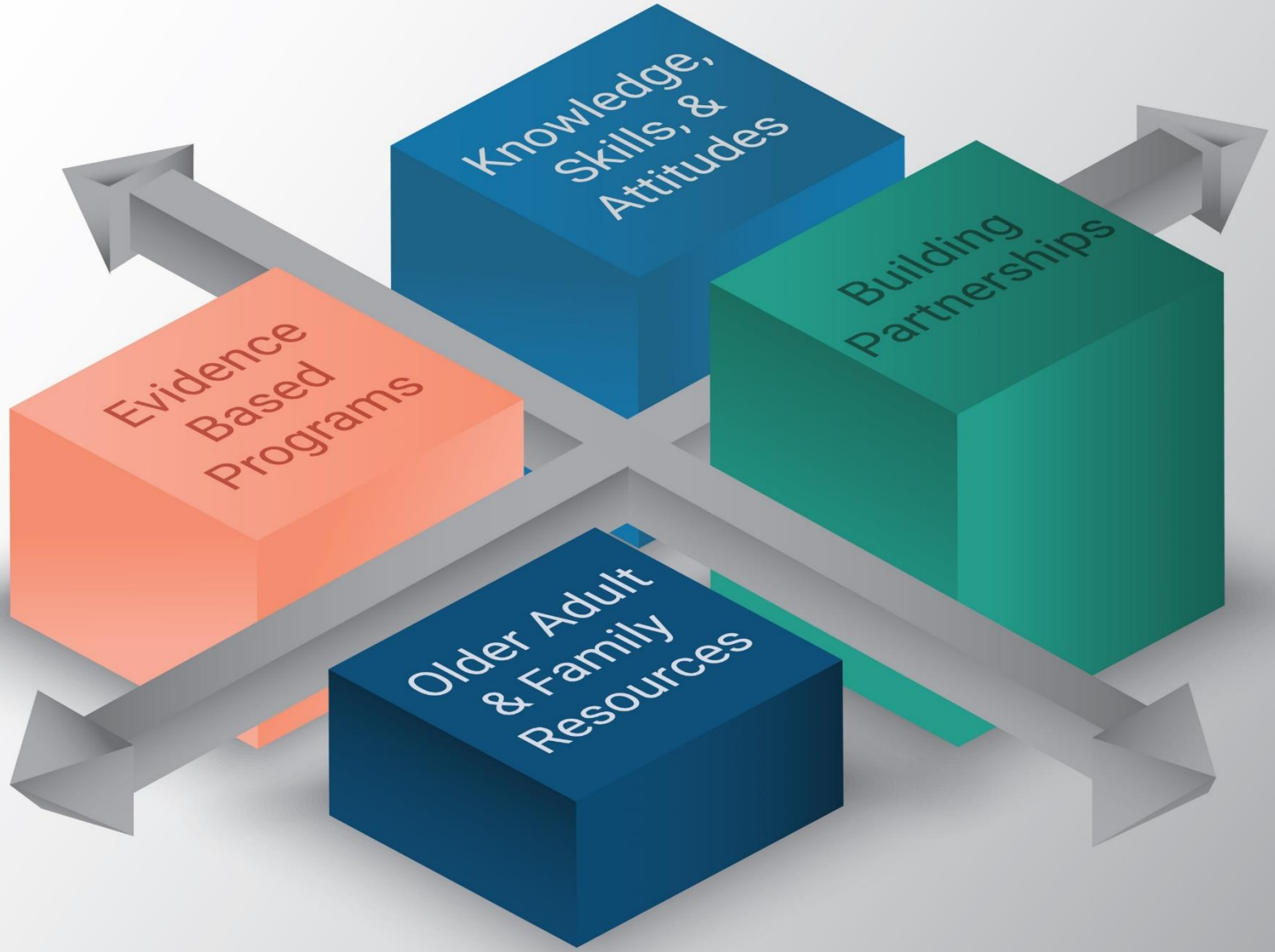

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Aging and Traumatic Brain Injury: Understanding the Intersection and Implications

Teresa Ashman, PhD, ABPP-RP

Wednesday, July 10

10-11:30 PT/11-12:30 MT/12pm-1:30 CT/1-2:30 ET

Caregiving in Aging Families

Sara Qualls, PhD, ABPP

First Three Fridays of September

8-11AM PT/9AM-11AM MT/10AM-12PM CT/11AM-1PM ET

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10

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HOT OFF THE PRESSES!

Anti-Elderspeak Language Guide

CATCH-ON COMMUNITY HEALTH

We are ALL aging – how would you want to be spoken to?

Through verbal and non-verbal language, we can celebrate adult personhood by acknowledging and honoring older adults' unique identities, yet our speech can get in the way. Elderspeak uses over-simplified language and is often driven by ageist stereotypes or the belief that accommodation is needed. While aimed at expressing care or enhancing comprehension, it is demeaning, and can make caregivers seem less respectful or nurturing, dominant, and unfriendly.

Reframing Aging

Try saying this:	Instead of saying this:	Because:
Older Adult/Person/People	Senior/Senior Citizen Elderly	Implies frailty, dependence, and perpetuate stereotypes
Person with dementia or cognitive impairment	Demented Senile	Disrespectful and contributes to stigma
"You are beautiful!" "You have a vibrant energy!"	"You are beautiful for your age! "You are young at heart!"	Implies that youth is superior, and aging is shameful or undesirable
"How can I help you be safe?" "I admire your independence. Do you need any support?"	"Should you still be doing that?" "You live alone at your age? You're so independent!"	Can discourage activity and implies that getting older guarantees dependence or inability to perform tasks

https://catch-on.org/wp-content/uploads/2024/05/Anti-Elderspeak-Language-Guide-CATCH-ON-2024.pdf

Normal Cognitive Aging and Dementia: What Counselors and MFTs Need to Know

Suzanne Musil, PhD, ABBP-CN

06-20-2024

Grant#: 6H79FG000600-01M001

SAMHSA's mission is to reduce the impact of substance misuse and mental illness on America's communities.

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Disclosures

I have no relevant financial relationships to disclose.

Objectives

By the end of this presentation, learners should be able to:

- describe normal age-related change in cognitive abilities
- differentiate between normal age, mild cognitive impairment, and dementia
- recognize the distinct memory impairment seen in Alzheimer's disease
- use appropriate communication for persons with and without dementia
- assist older patients with lifestyle adaptations to reduce risk of future cognitive decline

Outline

Part 1: Normal

- brief overview of brain anatomy and function
- cognition and normal aging

Part 2: Abnormal

- normal cognitive aging versus mild cognitive impairment versus dementia

---- BREAK ----

- treatable causes of cognitive impairment

Part 3: Working with older adults

- communication strategies for older adults with and without cognitive impairment
- prevention

Janet: First encounter

76-years-old

background

- retired school teacher
- married for 53 years, recently widowed
- 3 children, 5 grandchildren

presenting problem

- husband died from cancer and she was his caregiver
- you are seeing her for adjustment to widowhood

medical history

- hypertension
- borderline diabetes
- mildly high cholesterol
- arthritis
- hypothyroid

Medications

- lisinopril
- levothyroxine
- ibuprofen

Janet: 1st encounter

cognition

- feels like her memory has been “not so good” over the last couple of years
- forgets why she got up to do something
- misplaces her glasses
- trouble coming up with words she wants to use

function

- described herself as fully independent
- makes appointments with you on her own; never misses
- fairly good carryover between sessions, but sometimes you need to remind her

Janet: 1st encounter

What matters

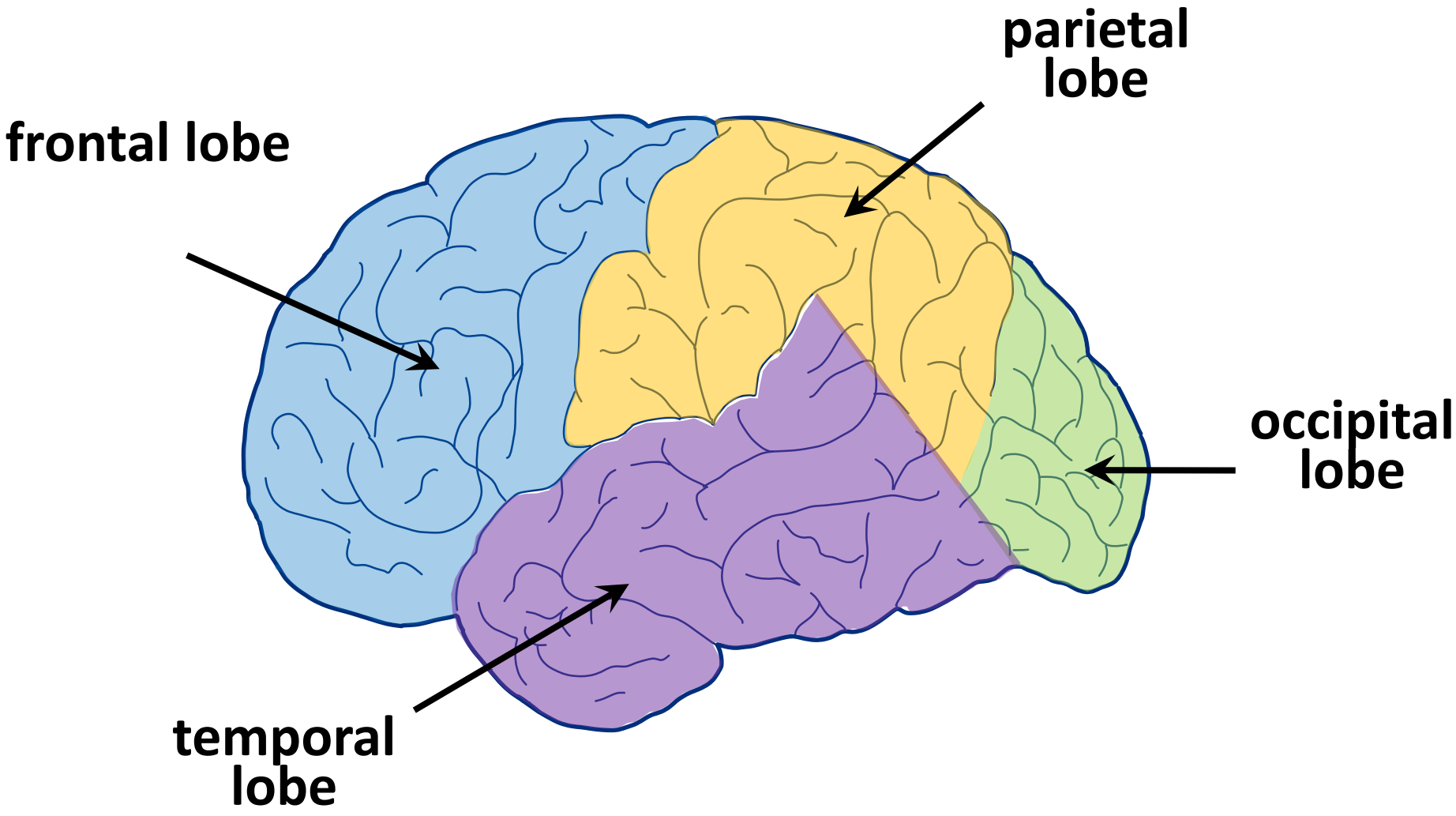
- to be self-sufficient
- to stay as independent as possible
- play an active role with her grandchildren

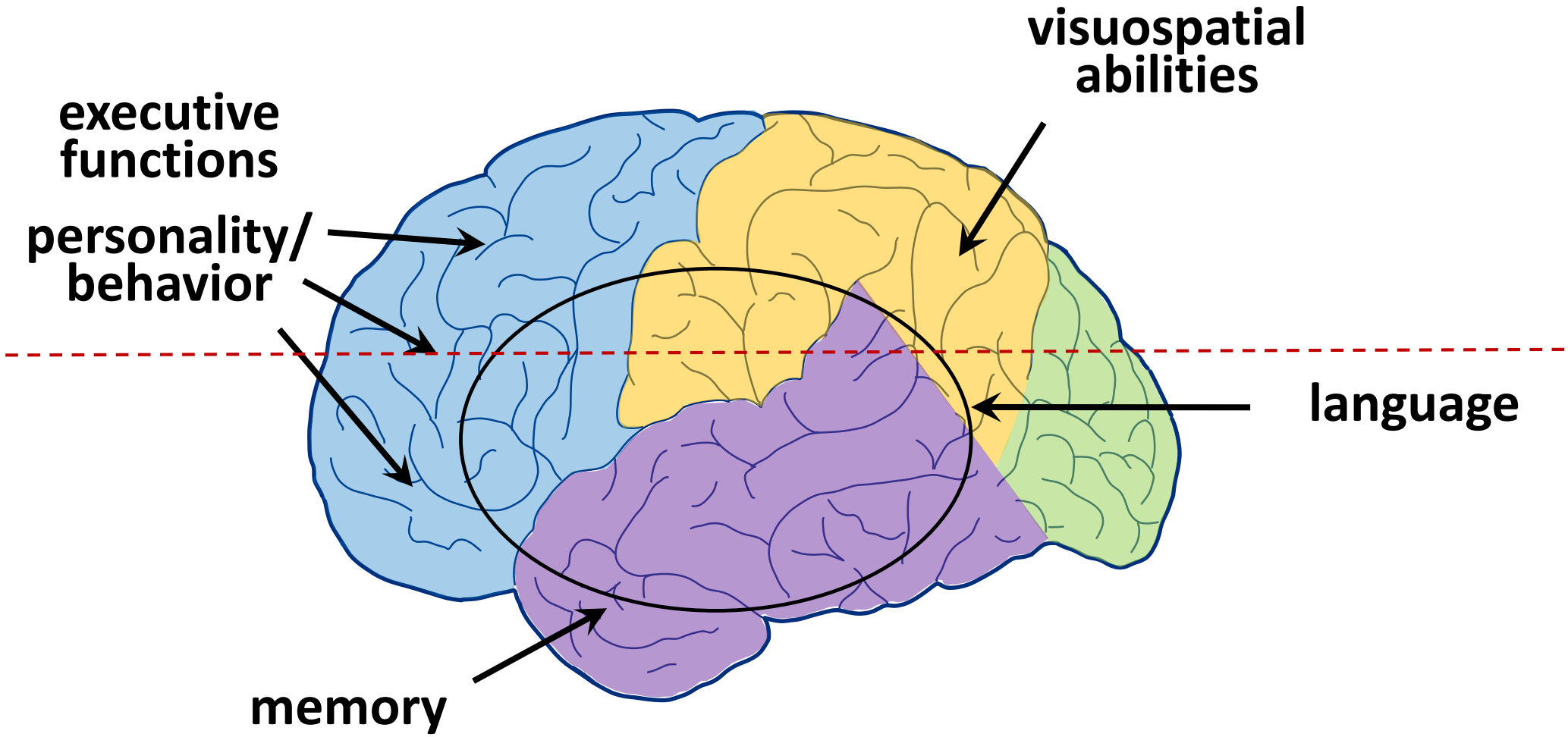
Normal?

Abnormal?

Normal aging

- Brain function
- Cognition

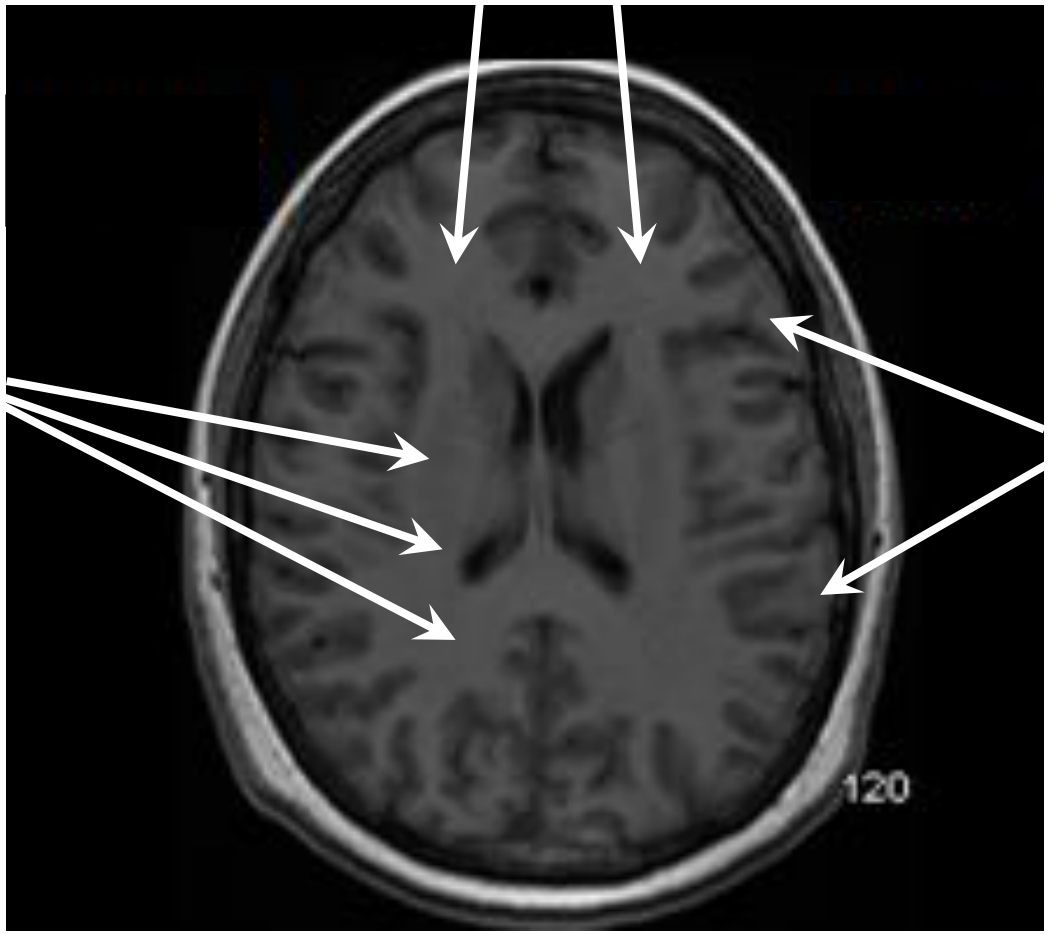

parietal lobe
frontal lobe
occipital lobe
temporal lobe


visuospatial abilities
executive functions
personality/ behavior
language
memory

frontal lobes

white matter –
connect brain areas

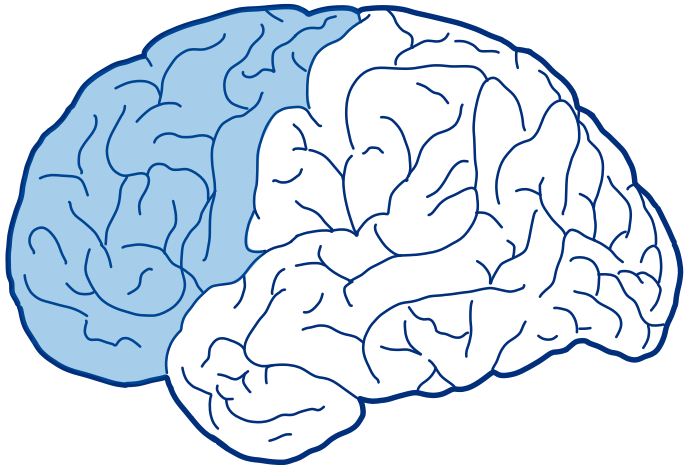
information “highways”



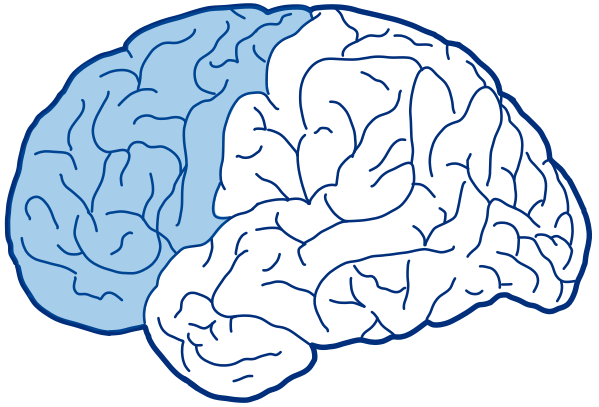
cortex –
where conscious thought processes take place

How does the brain age “normally”?

- “normal” can be hard to define
- we see same changes in normal aging and disease
- there is loss of brain volume
  - atrophy
- white matter changes
  - loss of connections
  - vascular changes
- reduced blood flow
- most changes are seen in the frontal lobes

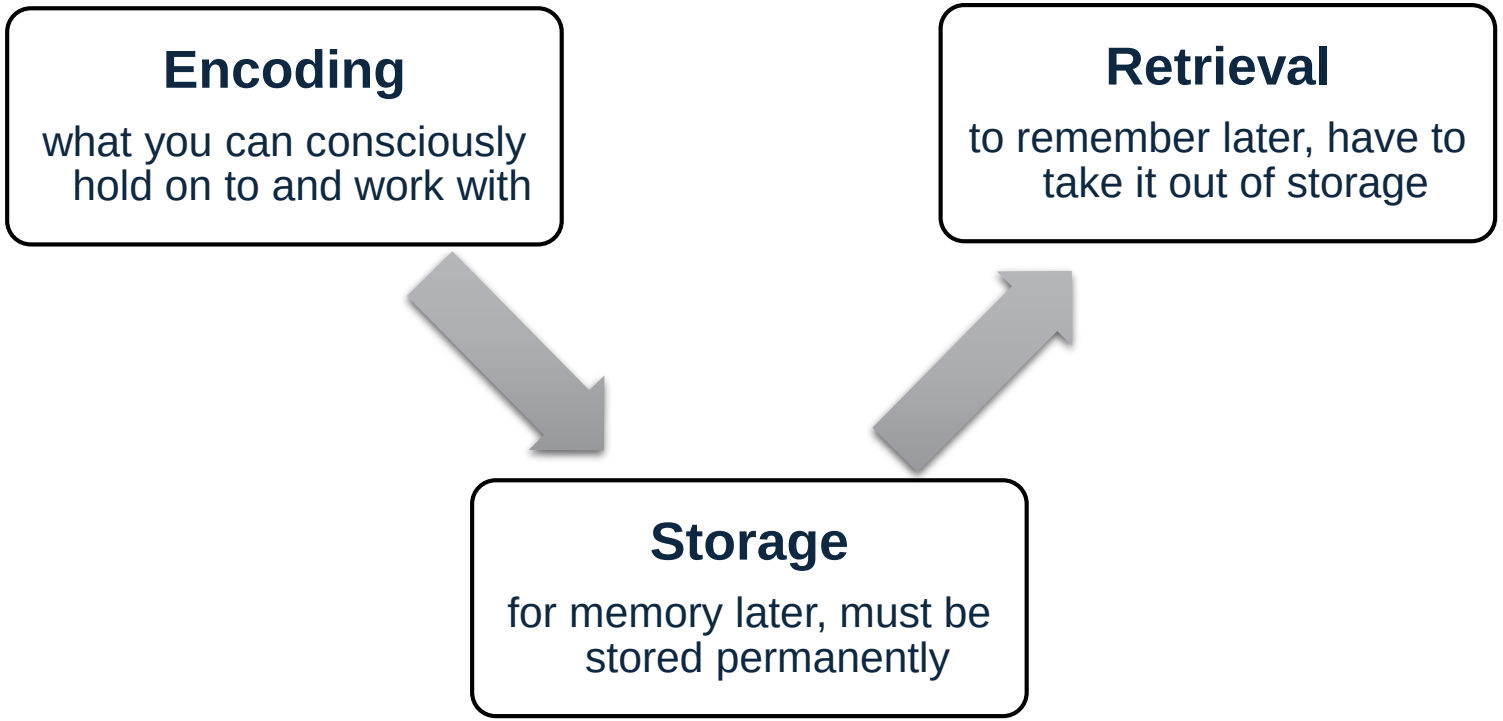


Frontal lobe functions



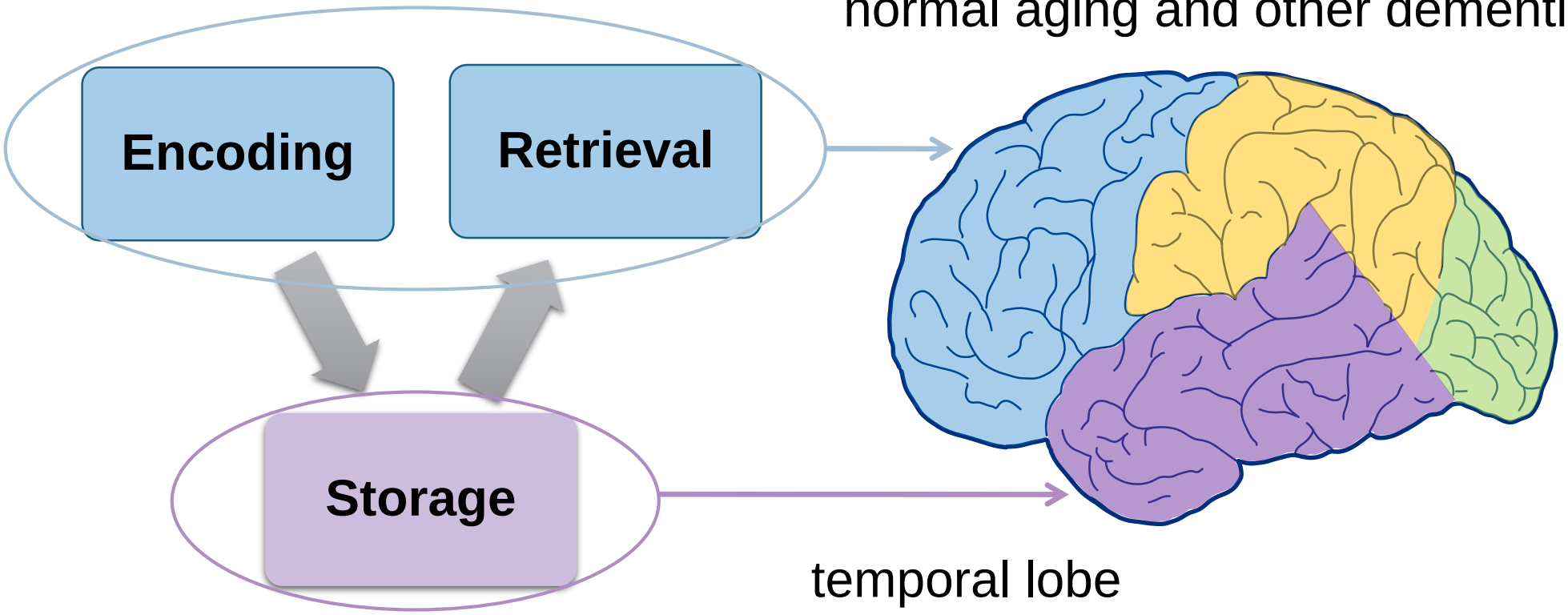
- “executive functions”
  - high level thinking abilities that allow us to execute appropriate behavior for the situation
    - monitor behavior and environment
    - planning, problem solving, mental flexibility, organization, reasoning, judgment, etc.
- also assist with memory

Memory works in stages



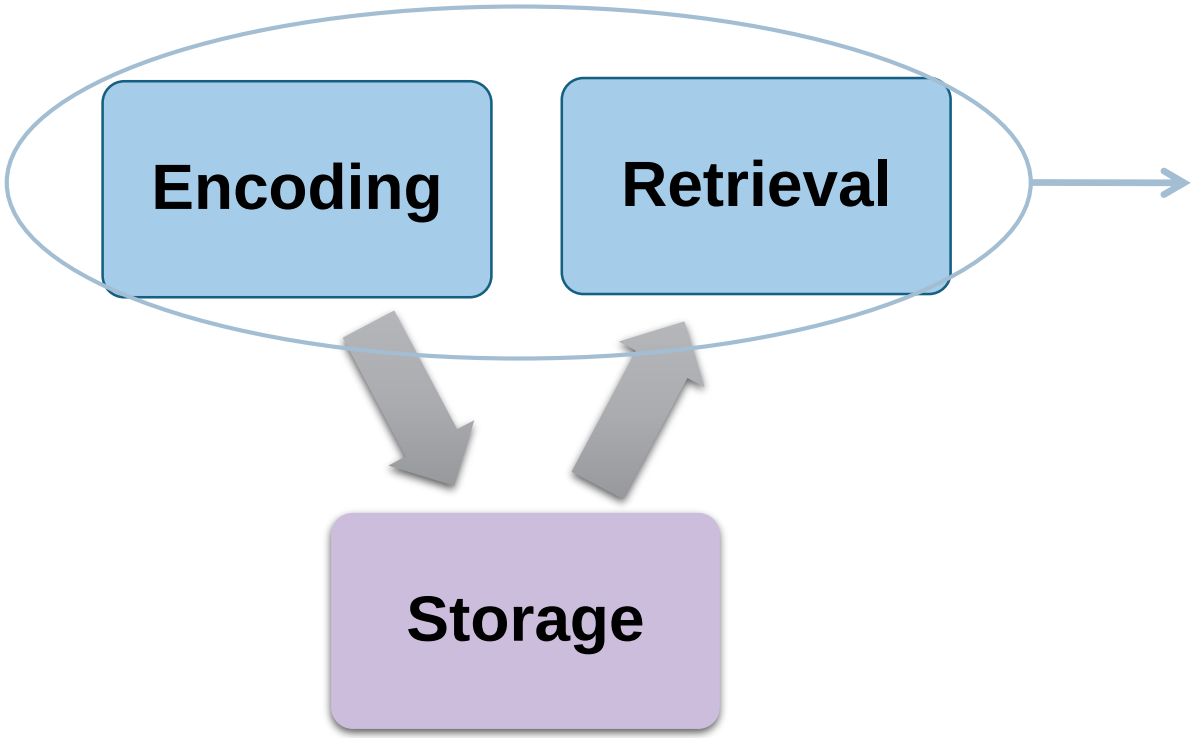
frontal lobe / white matter

normal aging and other dementias



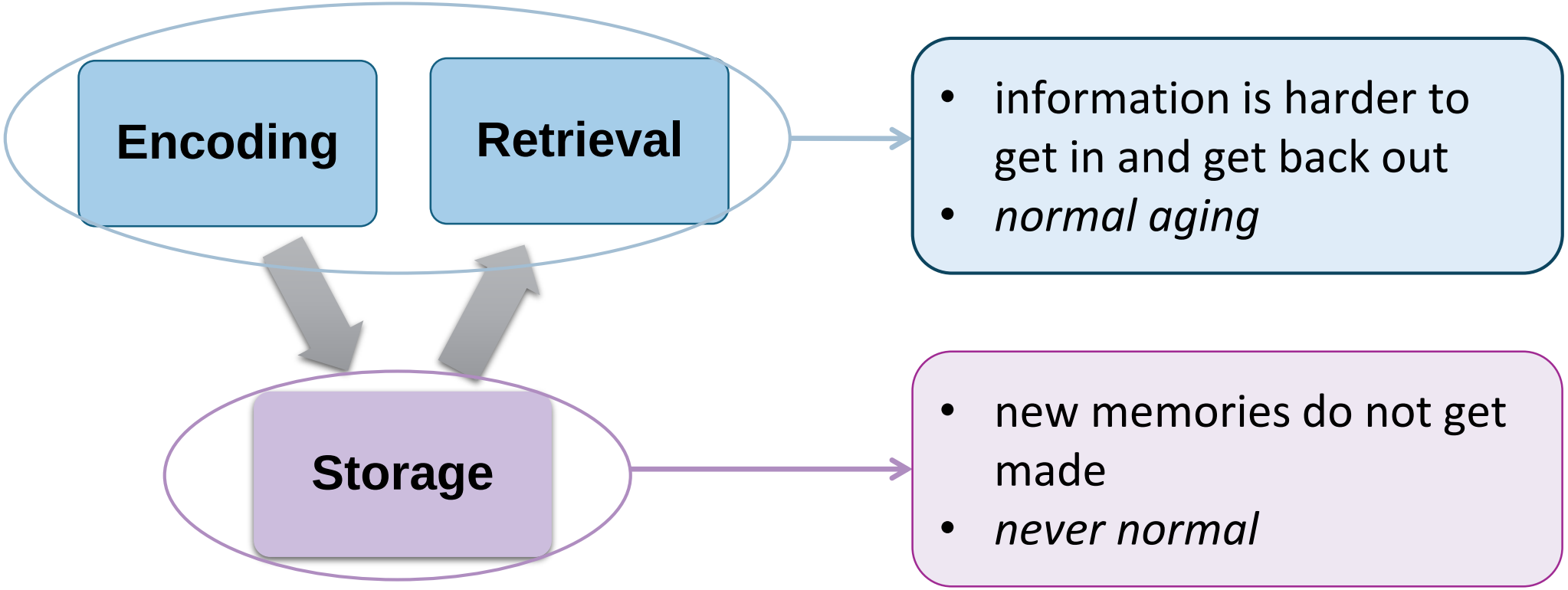
temporal lobe

Alzheimer’s disease



“present moment”
depend on attention

Two types of memory impairment



Other normal, age-related cognitive changes

attention

- *basic attentional abilities remain intact*
- *speed of processing declines*

language

- *some word-retrieval problems*
- *otherwise, preserved*
- *vocabulary grows with age*

executive function

- *declines in many aspects*
- *other aspects preserved*

visuospatial abilities

- *generally stable*

Not Normal Aging

- problems sustaining attention
- certain kinds of memory problems
- difficulty understanding or expressing language
- visuospatial problems
- significant changes in personality and behavior, problems with:
  - social behavior
  - judgment
  - awareness

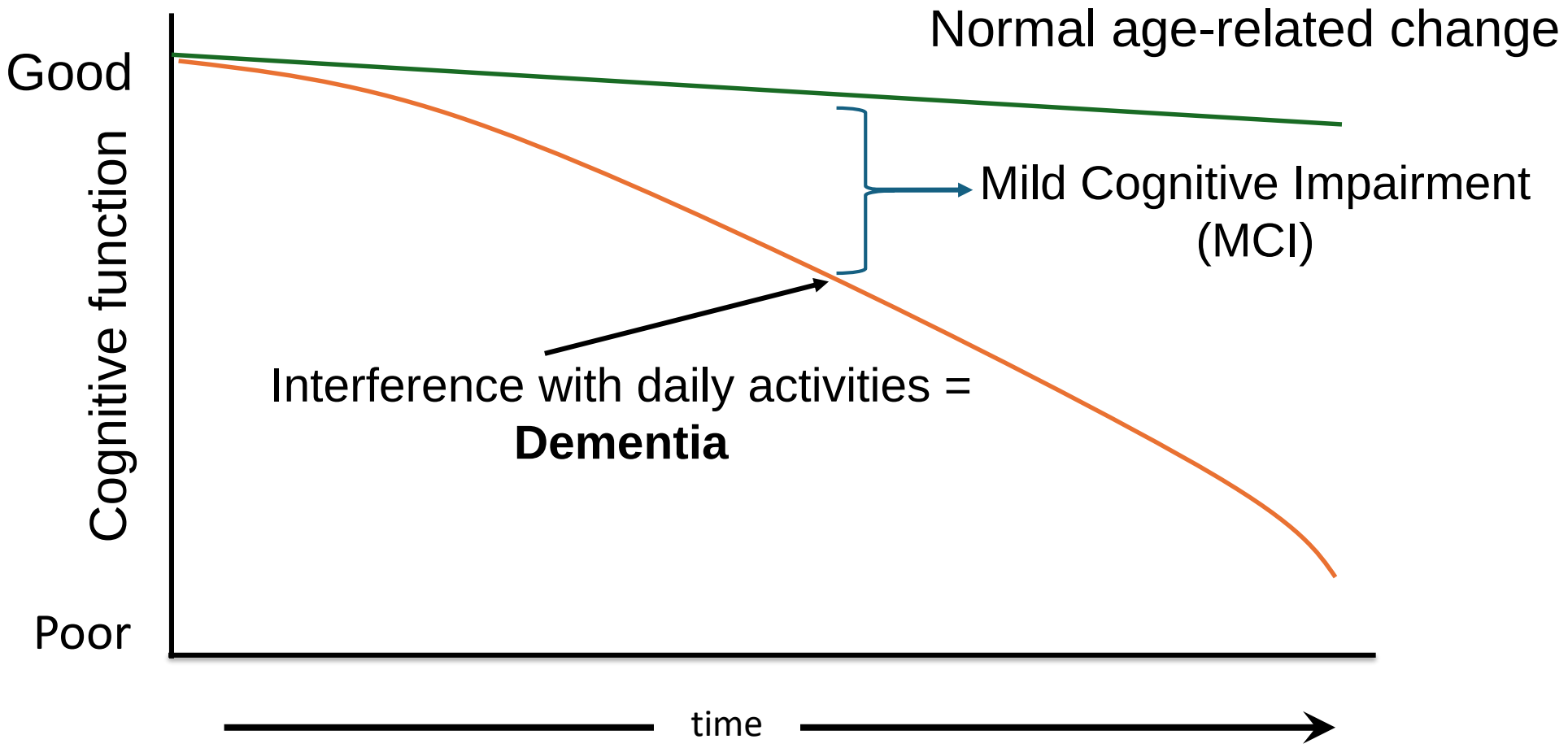
Normal or abnormal?

- work with Janet for 4 months
- she makes good progress
- terminate treatment

1st encounter: termination

From Normal to Dementia

From normal aging to dementia



Dementia: Umbrella term for multiple diseases

2 criteria

- “Significant” decline in cognition or behavior
- Interferes with a person’s ability to carry out daily activities

Dementia diagnosis is confusing

dementia and MCI are different names for different stages of ***same*** disease

- MCI originally conceptualized to reflect the pre-dementia stage of Alzheimer's disease
- any dementing process will have a corresponding MCI
  - the stage between normal aging and functional impairment
- MCI is a risk factor for dementia

Dementia diagnosis is confusing

- diagnosis can represent:
  - the disease
    - e.g., Alzheimer's disease
  - where in the brain the disease starts
    - frontotemporal degeneration
  - the clinical presentation of the disease
    - primary progressive aphasia

All 3 of these labels may be correct!

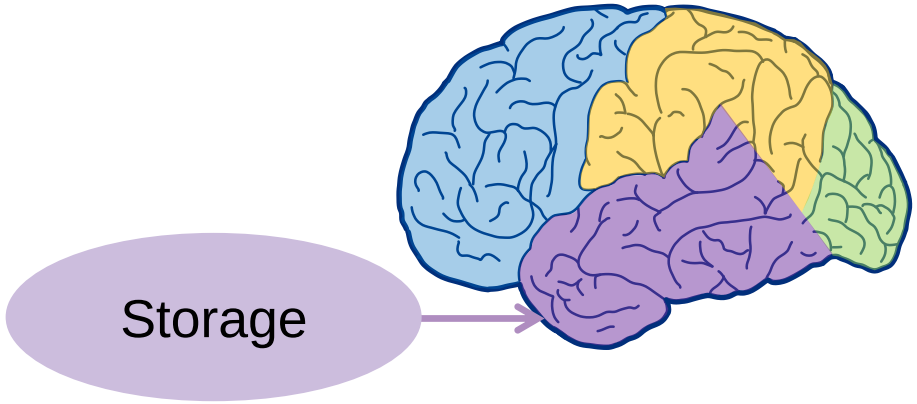
early clinical presentation correlates with neuroanatomy, NOT pathology

- focal vs diffuse

Two types of memory problems

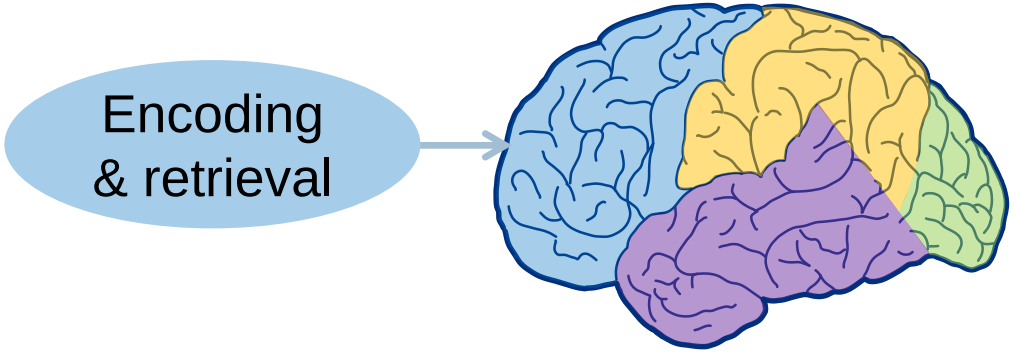
Storage

- inability to make/store new memories
  - poor memory for recent events
  - memories made prior to the disease are preserved
- little to no insight



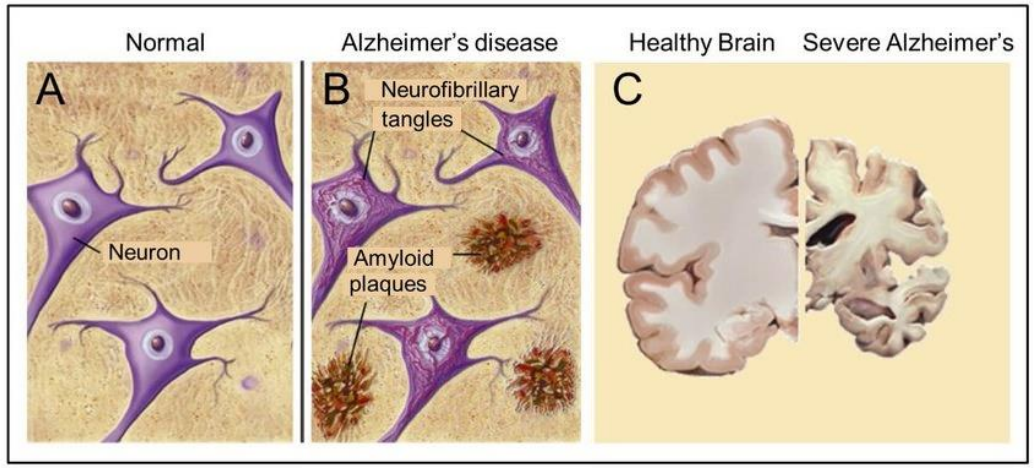
Encoding and retrieval

- memories do get made; inefficient, inconsistent
- hints and cues can help
- patients usually aware of the problem



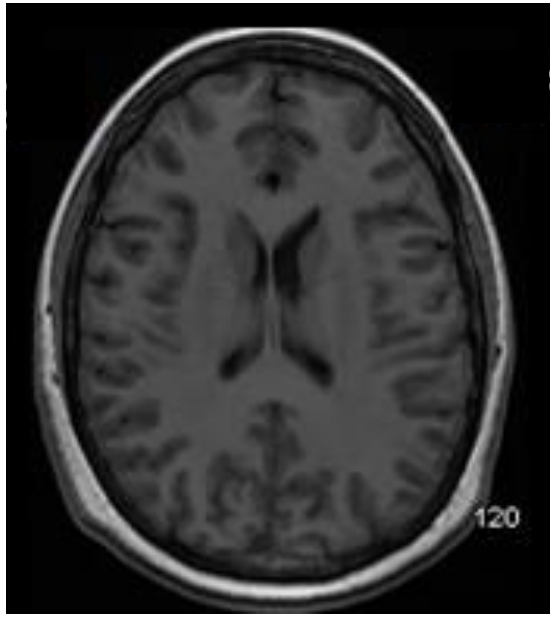
Alzheimer's disease – Early presentation

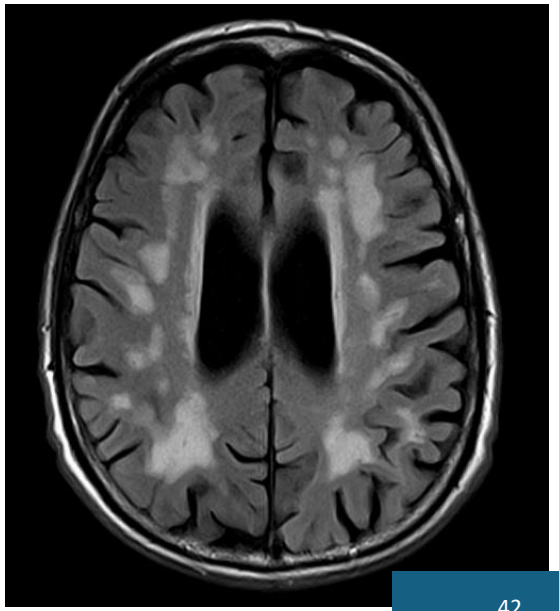
- most common: 60-80% of cases
- cause: abnormal proteins accumulate, cause cell death (atrophy)
  - plaques and tangles
- temporal lobe memory centers (focal)
  - storage problem
- cognition:
  - poor memory for recent events
  - naming/word-finding
  - lack of insight

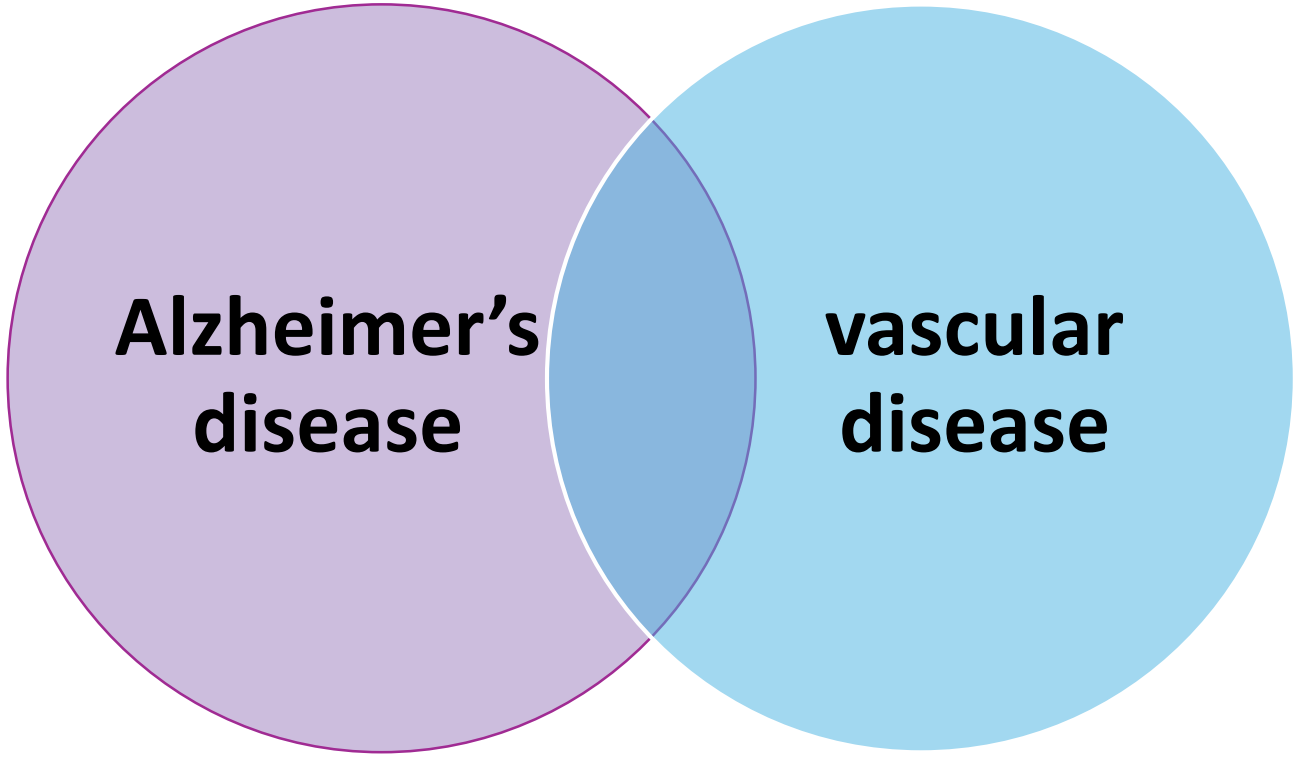


Vascular disease – Early presentation

- 2nd most common cause of cognitive decline
- cause: microvascular ischemic disease (diffuse) or stroke (focal)
- associated with high blood pressure, diabetes, high cholesterol, etc.
- other risk factors: smoking, obesity, age
- cognition:
  - memory encoding/retrieval
  - slow processing speed
  - executive dysfunction







= 75% of dementia cases

2nd encounter:
6 months after terminating 1st treatment

Update on Janet

- Janet contacts you to resume treatment
- grandson was killed in an accident 2 months ago – highly depressed
- neglected her health for several months
  - blood pressure uncontrolled
  - diabetes
  - high cholesterol
- daughter stepped in to help out

2nd encounter:
6 months after terminating 1st treatment

cognition

- Janet feels like she is “losing it”
- afraid she has Alzheimer’s disease
- much more forgetful, repeats herself, frequently misplaces things

function

- daughter oversees medications and appointments, brings her to sessions
- more forgetful about session content

What's going on now?

~~Normal?~~

~~MCI?~~

~~Dementia?~~

Why not dementia?

- don’t diagnose a chronic condition in the presence of acute factors

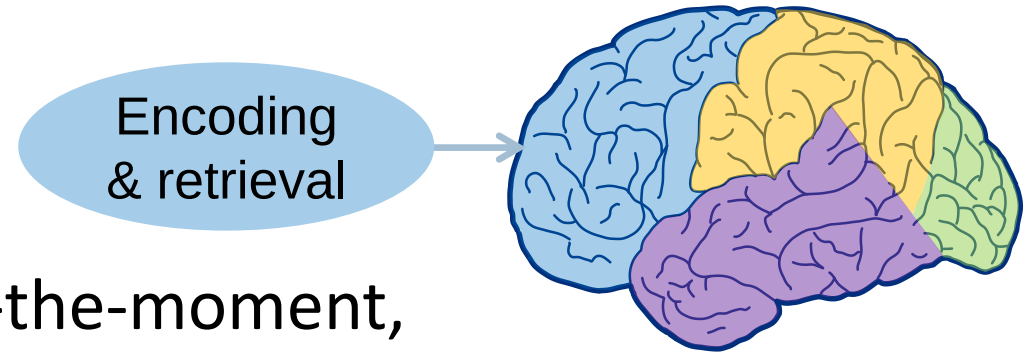
some causes of cognitive impairment are treatable – Janet meets criteria for major depressive disorder

Treatable causes of cognitive impairment

Depression and memory

- most psychiatric diagnoses have a criterion of cognitive impairment
  - problems with attention and concentration

- attention-based memory problems



- things that take away from attention in-the-moment, will cause encoding and retrieval memory problems

pain

fatigue

depression

anxiety

feeling ill

poor sleep

Treatable Causes of Cognitive Impairment

- mood disturbance
  - age-appropriate mood screening
- nutritional deficiency
  - medical evaluation
- obstructive sleep apnea
  - referral for sleep study
- delirium
  - acute confusional state due to a medical condition

Delirium: A variety of disturbances

consciousness

orientation

perception

sleep –
wake cycle

thought
processes

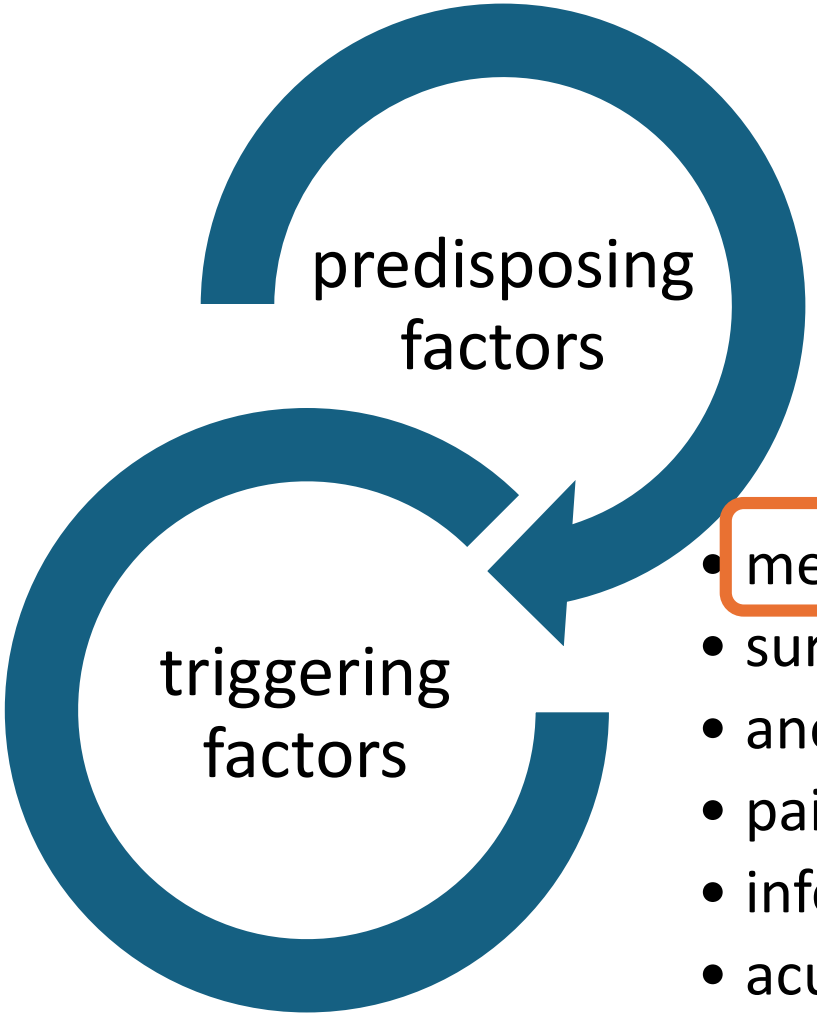
behavior

cognition

Cognitive Presentation

- profound attentional disorder, affects all other thinking skills
- memory is impaired because they can’t process information very well or quickly
  - encoding problem

Delirium risks/causes

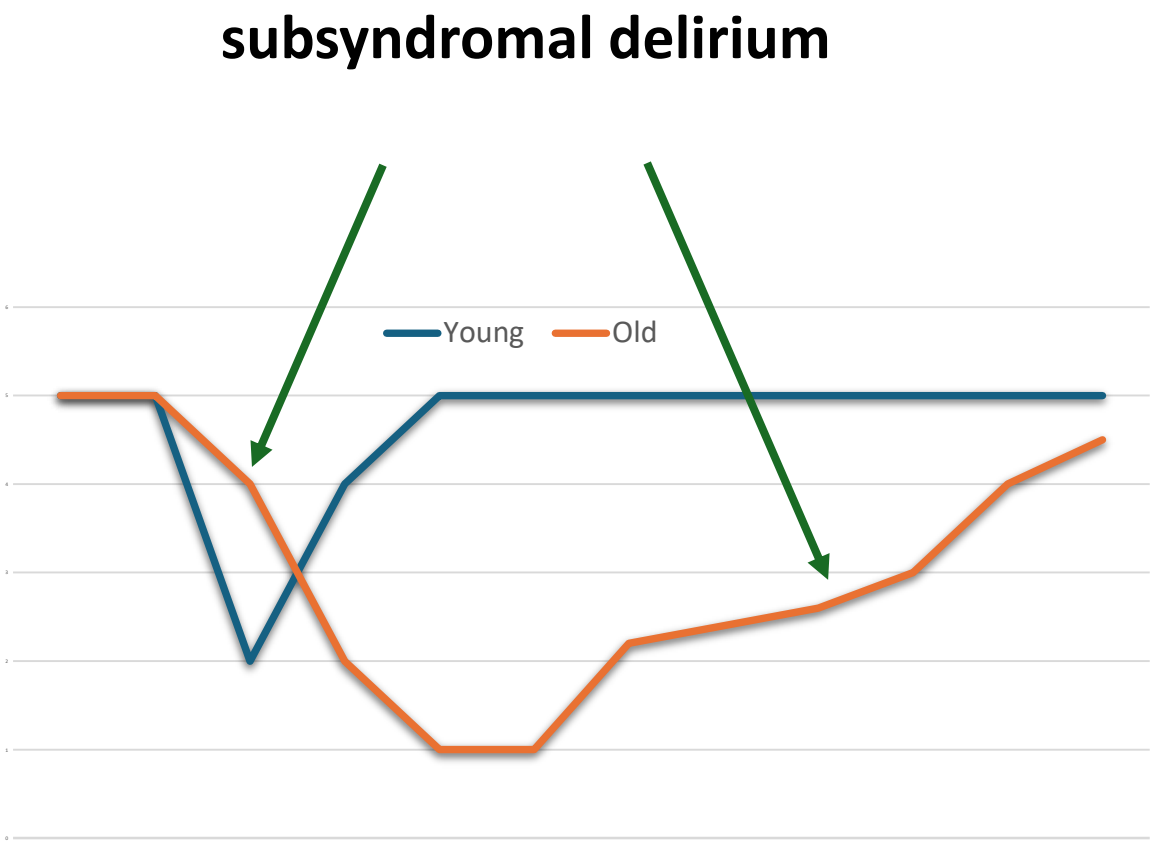


- older age
- baseline cognitive impairment
- functional disability
- sensory loss
- multiple co-existing medical problems

- medications
- surgery
- anesthesia
- pain
- infection
- acute illness

Delirium in older adults

- more frequent and more serious
- occurs with less provocation
  - could be multiple subclinical problems
- onset and recovery are slower
  - especially with pre-existing cognitive impairment
- misdiagnosis is common
  - as depression
  - as dementia



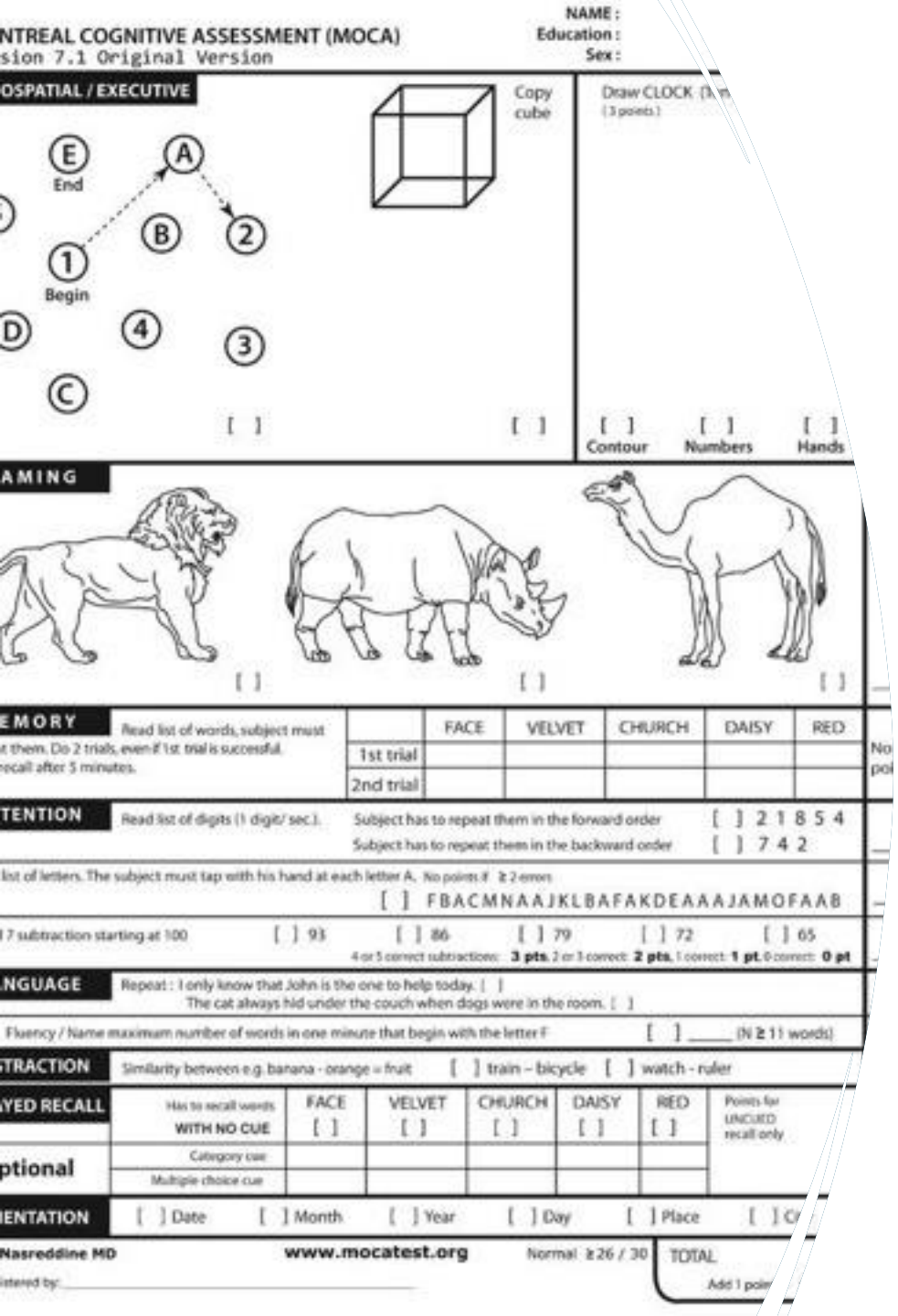
Delirium awareness

- for abrupt changes in cognition, consider medical etiology *before* dementia diagnosis
- ask about all medications, especially new ones
  - prescription AND over-the-counter
  - vitamins
  - supplements
- does the person get all medicines from the same pharmacy?
- check American Geriatrics Society Beers Criteria®
  - potentially inappropriate medication use in older adults
- are all medical providers in communication with each other?
- discuss with primary care doctor

2nd encounter:
6 months after
terminating 1st treatment

Janet: next steps

- strong temporal correlation between onset of depression and onset of memory problems
- could be medical etiology
  - worsened vascular health
- ask about sleep
  - no sleep apnea
- ask about all medications and supplements, are any new?
  - she's been taking Benadryl to fall asleep, advise her to stop
- consider cognitive evaluation


NTREAL COGNITIVE ASSESSMENT (MOCA)
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NAME :
Education :
Sex :
OSPATIAL / EXECUTIVE
Copy cube
Draw CLOCK
(3 points)
End
Begin
Contour
Numbers
Hands
AMING
EMORY
Read list of words, subject must
t them. Do 2 trials, even if 1st trial is successful.
ecall after 5 minutes.
FACE
VELVET
CHURCH
DAISY
RED
1st trial
2nd trial
TENTION
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
list of letters. The subject must tap with his hand at each letter A. No points 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
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
NGUAGE
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. [ ]
Fluency / Name maximum number of words in one minute that begin with the letter F
[ ] ____ (N ≥ 11 words)
TRACTION
Similarity between e.g. banana - orange = fruit
[ ] train – bicycle
[ ] watch - ruler
YED RECALL
Has to recall words
WITH NO CUE
FACE
VELVET
CHURCH
DAISY
RED
Points for UNCUED recall only
Category cue
Multiple choice cue
ptional
IENTATION
[ ] Date
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[ ] Day
[ ] Place
Nasreddine MD
www.mocatest.org
Normal ≥ 26 / 30
TOTAL
Add 1 poi
istered by:

Assessing Cognition

- screeners are helpful for staging, not determining dementia type
- memory assessment is not adequate:
  - can't determine type of memory problem
- formal neuropsychological evaluation is best
  - assess cognition in the context of premorbid ability, motivational factors, etc.
  - very sensitive to very early cognitive changes from neurodegenerative disease

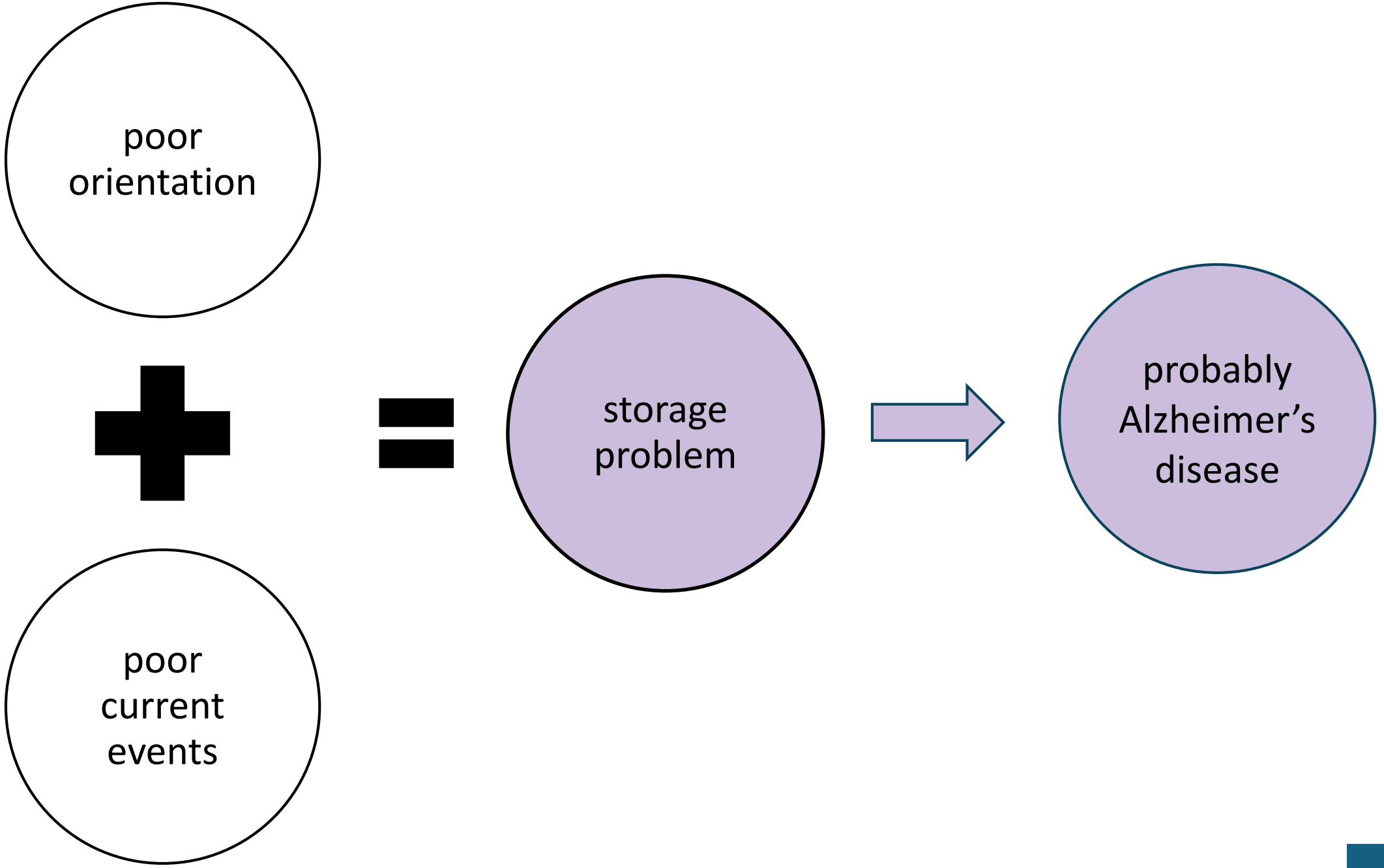
Assessing memory storage informally in the office

temporal orientation

- date:
  - month, year, and exact date
- day of the week
- time of day

current events

- Do you keep up with news?
- What's going on the news these days?
  - It's OK to give a hint to get them started.


poor orientation
poor current events
storage problem
probably Alzheimer's disease

2nd encounter:
3 months after resuming treatment

depression is greatly reduced

cognition

- memory is better, but not back to where it was when you first saw her
- same type of memory problem – encoding and retrieval

function

- benefits from memory support
  - provide written information to supplement sessions
  - repeat main points
- independent again

What's going on now?

- Janet may have MCI – you suspect a vascular cause, *not* Alzheimer's disease
- refer her for neuropsychological evaluation

Working with older adults

- **Communication**
- **Prevention**

What's wrong with this communication?

Tips for effective communication with cognitively normal older adults

- #1: don't assume!
- *do* make adjustments for normal cognitive aging

the cognitive change	the solution	there is no need to:
• *slower processing speed*	• don't speak too fast • allow a little more time for processing	• use simple words • speak slowly • shout • use "baby talk"

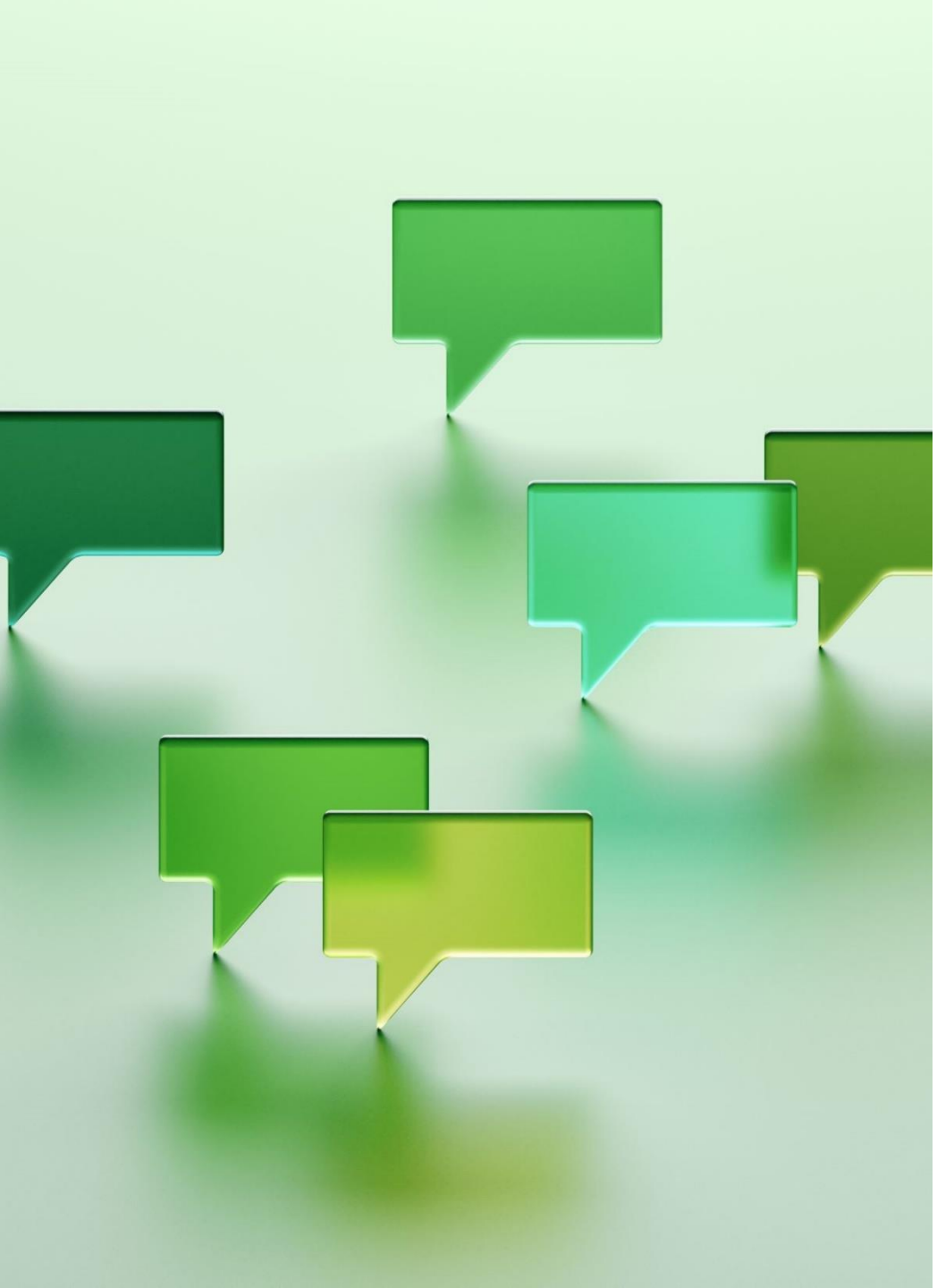
communication that treats a person like a child or a pet

- high-pitched voice
- using overly endearing terms
- using the collective “we”

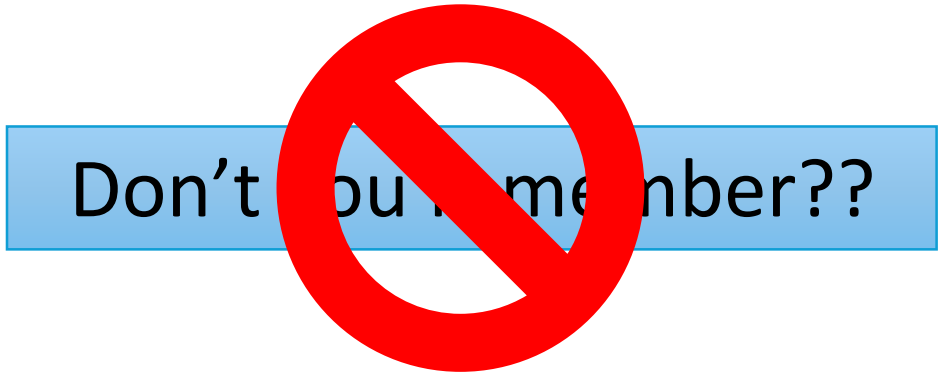
Other adjustments to communication

the change	the solution	there is no need to:

• *hearing loss*
  • more common in men
  • affects higher-frequency pitch
	• *"low and slow"*
	  • pitch voice lower
	  • slow down rate
	• remove background noise
	• try written communication
		• scream, shout
		• automatically direct speech to others



Communication with cognitively impaired older adults



Set the stage

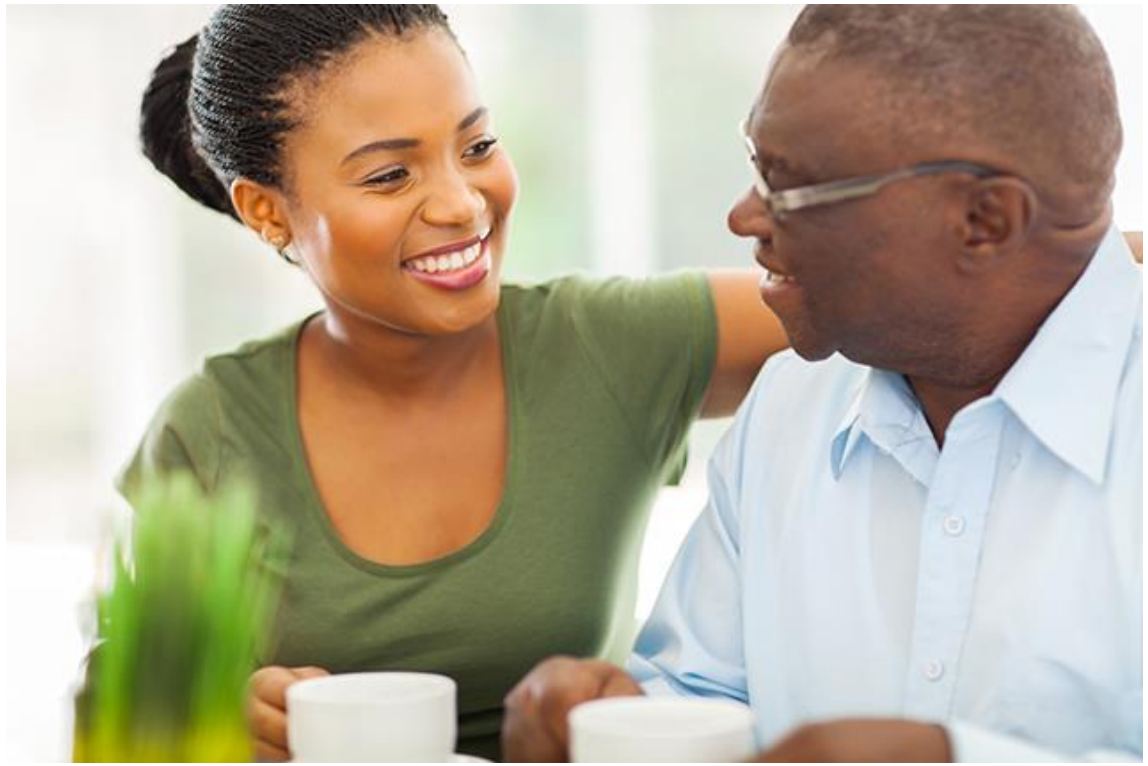
- approach the person from the front, at their eye level
- sit down if possible
- make eye contact
- remedy any sensory deficits
  - eyeglasses
  - hearing aids
  - lighting

What you say

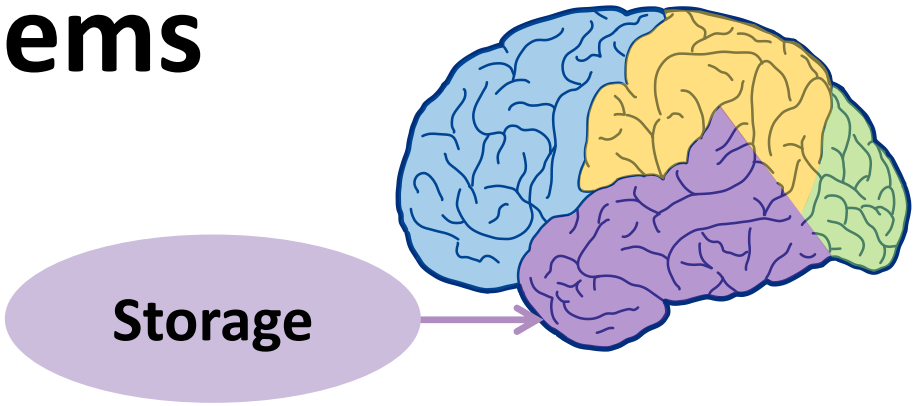
- introduce yourself and your role
- use the person’s preferred name
- explain what you are doing and why
- ask one thing at a time
- give choices whenever possible
- don’t argue, correct, or try to convince
- do provide comfort and reassurance

How you say it

- don’t use elderspeak
- be attentive to the person’s behavior
- be patient, and allow time for a response
- be aware of your own feelings and how they may impact care
- be aware of your own nonverbal behavior
  - e.g., tone of voice, facial expression, etc.
  - show you are listening

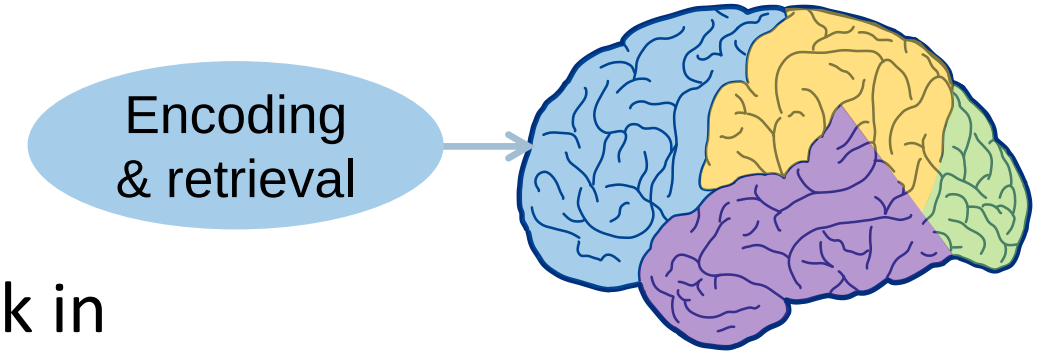


Adjusting for memory problems



- storage problems
  - i.e., Alzheimer's disease
  - memory for recent events will be poor
  - hints and cues are *not* helpful
    - and can increase distress, frustration, suspiciousness
  - repeating stories or questions is common
    - the person *does not remembe*r asking before
    - there is no need to remind them, just answer the question again

Adjusting for memory problems



- encoding/retrieval problems
  - important recent information will sink in
  - hints and cues *are* helpful
    - giving a little extra context can help bring out a memory
  - repetitiveness can be common, but
    - information given again will be familiar

How do we have conversions with older persons *about* cognition?

Why patients might not discuss memory loss with their providers

- stigma about memory loss
- fear of the consequences of the diagnosis
- why get a diagnosis if there is no cure
- bringing it up may just bring more referrals or prescriptions they don’t want
- may be unconcerned, think it’s normal

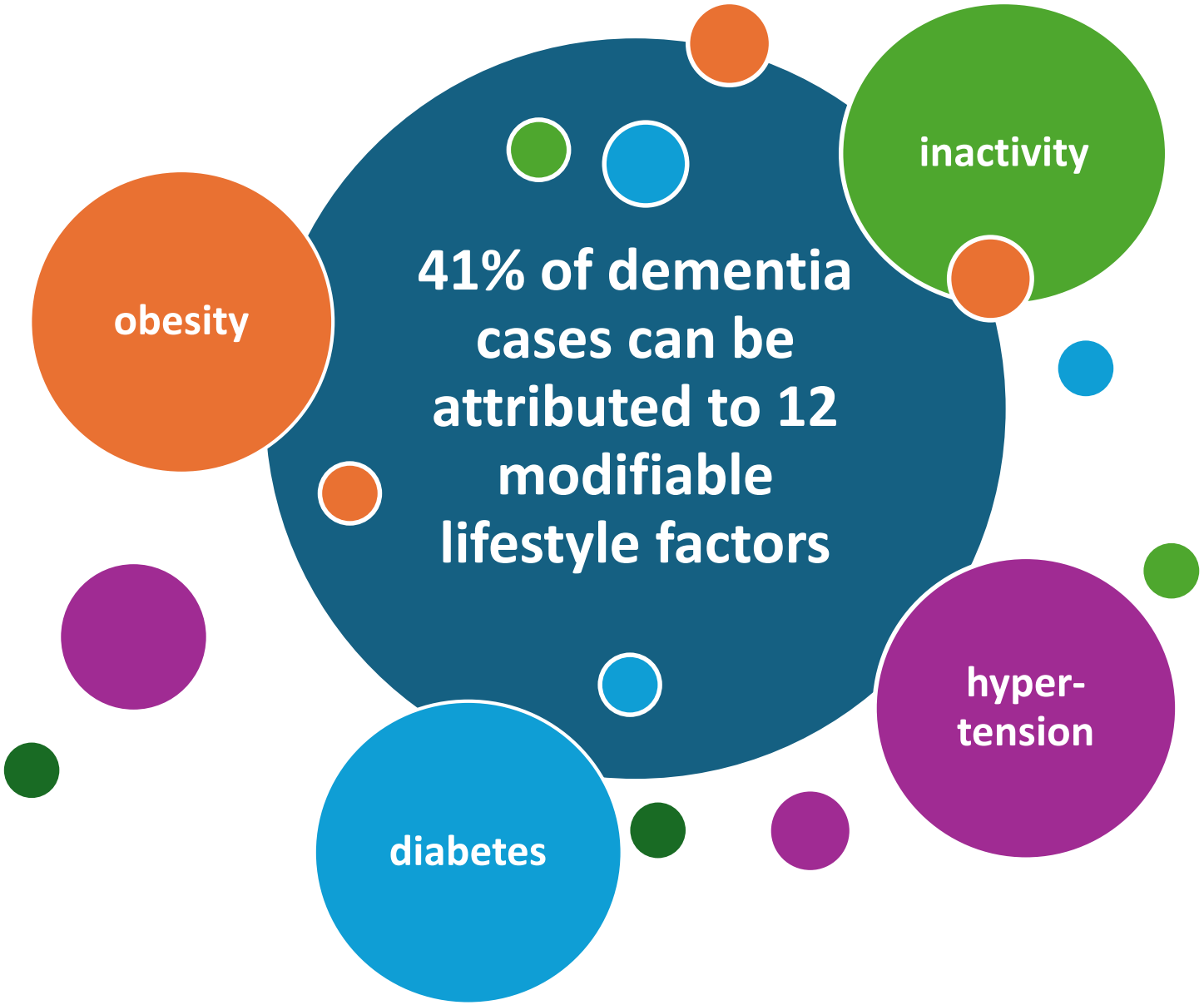
Why *providers* might not discuss memory loss with their patients

- may defer to patients or family members to bring it up
- may be awkward or uncomfortable
- it's a difficult conversation
- lack of specialists to refer patients to
- health care providers want to treat – there is little to offer patients

Overcoming barriers

have conversations early

- ask what matters
- encourage open family communication
- talk about advance directives: they're about life
- be open about limitations of treatment, but
- let patients know what a health care plan for memory might look like
- focus on prevention – positive approach



percentage is higher in Black and Hispanic Americans

it’s never too late to derive some benefit from a lifestyle change

Dementia Prevention

- manage cardiovascular health
- regular physical exercise
- heart-healthy diet
  - Mediterranean-type diet: MIND diet
- smoking cessation
- healthy sleep habits
- use hearing aids
- cognitive and social engagement

2nd encounter:
last few weeks of treatment

Janet:

- had neuropsychological evaluation: diagnosed with MCI - vascular
- assist with lifestyle modification to improve vascular *and* brain health and reduce her risk of progressing to dementia
  - education
  - motivation
  - overcoming barriers to adherence

Wrapping up – Take home points

with age, there is slowing of processing speed and memory encoding and retrieval problems

MCI and dementia are umbrella terms based on degree of cognitive impairment and level of independence

Alzheimer's disease causes a storage problem: difficulty retaining information over time

make adjustments in communication appropriate for the person

have conversations about cognition early and adopt a positive approach focused on prevention

For Janet…

- helped her avoid misdiagnosis
- saved her from unnecessary tests and procedures
- reduced her need for medications
- helped her retain her independence
- gave her tools to her reduce her risk for dementia in the future

Questions and Answers

Resources

Critical Resources on Medicare Part B Coverage of Counselors and MFTs

Legislation Mandating Medicare Part B Coverage of Counselors and Marriage and Family Therapists

https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

How to Enroll in the Medicare Program

- **Medicare Enrollment for Providers and Suppliers**
  https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos
- **New Provider Type: Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) FAQs (36 questions answered) Published Sept 2023**
  https://www.cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf
- **The Medicare Learning Network:**
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlngeninfo
- **Web-based Training:**
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining
- **Becoming a Medicare Provider (World of Medicare):**
  https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN9329634-WOM/WOM/index.html
- **Weekly Email Newsletter for Medicare Providers:**
  https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive

Critical Resources on Medicare Part B Coverage of Counselors and MFTs continued

Role of the Centers for Medicare and Medicaid Services (CMS)

- https://www.investopedia.com/terms/u/us-centers-medicare-and-medicaid-services-cms.asp
- https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive

Medicare Mental Health Benefits for Beneficiaries

Medicare and Your Mental Health Benefits:
https://www.medicare.gov/Pubs/pdf/10184-Medicare-and-Your-Mental-Health-Benefits.pdf

Medicare Mental Health:
https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf

Medicare Beneficiary Handbook:
https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf

Critical Resources on Medicare Part B Coverage of Counselors and MFTs continued

Medicare Administrative Contractors (MACs)

https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/what-is-a-mac

Medicare Physician Fee Schedule

https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

Key Steps to Becoming a Medicare Provider

1. Register in the I&A System
2. Get an NPI
3. Enter information into PECOS
4. Decide if you want to be a participating provider

Form CMS-855I: Physicians and non-physician practitioners (PDF link)


Thank you
for attending!
Medicare Mental Health
Workforce Coalition