

Affiliation Guidelines for the Wisconsin Alzheimer's Institute (WAI) Dementia Diagnostic Clinic Network

The Wisconsin Alzheimer's Institute (WAI) is an academic center within the University of Wisconsin School of Medicine and Public Health. The mission of the WAI is to improve the availability of services and the quality of care provided to persons with dementia and their families.

A major program area of the WAI is the development of dementia diagnostic centers throughout Wisconsin. The purpose of this program is to assist communities, physicians and health care organizations in developing and sustaining multidisciplinary diagnostic services that promote early diagnosis and treatment as well as support for caregivers. The goals of the program are to:

- Improve access to quality dementia diagnostic services throughout Wisconsin,
- Increase access to education and supportive services for patients and caregivers, and
- Participate in systematic and high-quality data collection for quality assurance, research, and public policy purposes.

To meet these goals, guidelines for WAI affiliated dementia diagnostic clinics are as follows:

1. The clinic must provide interdisciplinary care, defined as a group of health care professionals from diverse fields who work in a coordinated fashion toward meeting the needs of the patient and their support system. At a minimum, the team should include the services of a physician and, preferably a neuropsychologist and a social worker; or other team members who are trained to complete the functions of the evaluation (please reference evaluation function/task chart).
2. The clinic must be affiliated with a medical organization that provides space, scheduling assistance, modern laboratory and radiology services, an electronic health record, and an on-call service.
3. All clinics should have a relationship with their local Alzheimer's support agency and other relevant community and government entities (i.e. county aging, disability, and dementia care resource teams, etc.) that will provide longitudinal education and support to persons affected by Alzheimer's disease and related dementias as well as their support team.
4. Diagnoses should follow the following guidelines:
 - **Dementia (All-cause):** National Institute on Aging – Alzheimer's Association (NIA-AA) All-cause Dementia Criteria (McKhann, 2011)
 - i. **Alzheimer's Disease (AD) Dementia:** NIA-AA AD Dementia Criteria (McKhann, 2011)
 - ii. **Vascular Dementia (VaD):** NINDS-AIREN Criteria (Roman, 1993)
 - iii. **Dementia with Lewy Bodies:** DLB Consortium (McKeith, IF, 2017)
 - iv. **Parkinson Disease Dementia:** (Litran, I, 2003)
 - v. **Behavioral Variant Frontotemporal Dementia (bvFTD):** (Rascovsky, 2011)
 - vi. **Primary Progressive Aphasia (PPA):** (Mesulam, MM, 2003)
 - **Mild Cognitive Impairment:** NIA-AA Mild Cognitive Impairment Criteria (Albert, 2011)
 - i. **MCI due to AD:** NIA-AA Mild Cognitive Impairment Criteria (Albert, 2011)
 - ii. **MCI due to Vascular Injury (Vascular Cognitive Impairment [VCI])** (Albert, 2011, Roman, 1993)
5. The evaluation should include minimally the following:
 - A **medical evaluation** provided by a qualified physician or advance practice provider.
 - **Cognitive test administration** by a qualified and appropriately trained team member (please reference evaluation function/task chart).
 - i. A standard global cognitive screening exam. The **preferred tools** are:
 - (1.) the Mini Mental State Examination (MMSE),
 - (2.) Montreal Cognitive Assessment (MoCA),

- (3.) Saint Louis University Mental Status Examination (SLUMS), or
 - (4.) Mini-Addenbrook's Cognitive Examination (Mini-ACE)
- ii. One brief cognitive battery that evaluates key areas in a validated standardized manner. The **preferred tools** are:
 - (1.) RBANS (Repeatable Battery for Assessment of Neuropsychological Status)
 - (2.) NCSE/Cognistat (Neurobehavioral Cognitive Status Examination) or
 - (3.) ACE - R (Addenbrooke's Cognitive Exam – Revised)
 - iii. Based on clinician team preferences, additional cognitive measures may include (but are not limited to):
 - (1.) A category fluency measure. The **preferred tool** is the Animal Naming Screen; allowable substitutions are naming furniture, fruits, vegetables, items purchased in a grocery store, provided availability of appropriate norms.
 - (2.) A standardized measure of visual praxis. The **preferred tool** is the Clock Draw using standardized scoring methods. An allowable substitution would be the praxis items from the Consortium to Establish a Registry for Alzheimer's Disease (CERAD) battery.
 - (3.) A word list-learning test. The **preferred tool** is the word list from the CERAD battery; allowable substitutions are the Rey Auditory Verbal Learning Test and the California Verbal Learning Test or the Hopkins Verbal Learning Test.
 - (4.) A brief standardized measure of executive function. The **preferred tool** is the Trail Making Test for a quick measure of speed and cognitive flexibility; allowable substitutions are the Stroop Color-Word Test or the Wisconsin Card Sort Test (64-item version).
 - iv. Cognitive test data should be supported by information about everyday cognitive function provided by a support system member or other close informant.
- **Interpretation of cognitive tests** should be completed by a neuropsychologist or a psychologist. If such team members are not available for regular clinic participation, then a clinician formally trained by a licensed psychologist may interpret the cognitive testing. If a non-psychologist clinician interprets cognitive data for a clinic, then approximately 10% of the cases should be reviewed in conjunction with a licensed psychologist.
 - A **psychosocial evaluation** completed by a social worker or by a team member that is qualified and appropriately trained to complete the functions of the evaluation (please reference evaluation function/task chart).
 - i. An assessment of mood and behavior. The **preferred tool** for assessing mood is the short (15-item) Geriatric Depression Scale (GDS). Allowable substitutions include the Cornell Depression Scale in Depression or the Beck Depression Inventory-II, the Beck Depression Scale for Primary Care. The **preferred tool** for assessing behavior is the Neuropsychiatric Inventory Questionnaire (NPI-Q). An allowable substitution is the Revised Memory and Behavior Problems Checklist.
 - ii. An assessment of function. Information should be gathered from an informant about the patient's current and historical functional abilities, including the course of any changes. The **preferred tools** to assist in gathering information are the Powell and Lawton Instrumental Activities of Daily Living Scale and the Katz Index of Independence in Activities of Daily Living.
 - iii. An assessment of sleep. The **preferred tools** are the Epworth Sleepiness Scale and STOP BANG Questionnaire.
 - iv. A safety assessment to include such areas as wandering behavior, abuse and neglect, smoking material use, falls, driving, over-the-counter and prescription medication use/abuse, and guns, weapon, and power tool access.

- v. An assessment of caregiver burden and the individual's formal and informal support system. The **preferred tool** is the Zarit Caregiver Burden Interview. The assessment should include community and health system resource utilization, and other relevant information to assist with treatment planning referrals.
 - vi. An assessment of psychosocial history. Additional information should be gathered in such areas as: ancestry, cultural, spiritual, and religious influences; education and vocational background; hobbies, leisure, and recreational interests; housing; transportation; financial resources; and legal history.
 - vii. Conduct a discussion on advance care planning (including end-of-life matters if relevant), and complete an assessment of Advance Directives; fostering the opportunity to complete documents.
 - If the psychosocial evaluation is not completed by a master's level social worker; it is recommended the team member completing the function has experience in geriatrics, dementia care, and healthcare; and they receive training in the following areas: support system evaluation and caregiver burnout; abuse, neglect and reporting mandates; advance directive planning and completion; end-of-life matters; and relevant boundaries and ethics when working with individuals living with dementia. Until the team member has adequate experience in the relevant areas, it is recommended approximately 10% of the cases be reviewed with a master's level licensed social worker.
6. The clinic must be willing to participate in systematic and high-quality data collection.
 7. The clinic must be willing to provide educational and community services resource information to patients and caregivers.
 8. Physicians and other clinic staff must be willing to attend annual CME and Clinic Network meetings sponsored by the WAI.