INTERDISCIPLINARY CLINICAL PROCESS – Family Medicine Group (FMG) OUTREACH SERVICES

MILD OR MAJOR NEUROCOGNITIVE DISORDERS (mNCD or MNCD)

DIAGNOSIS COMPONENT (1)

NOTE: Rapid or acute deterioration is a potential emergency and must be treated by a doctor (e.g., delirium).

1. SCREENING[1] – *Systematic screening is not recommended.*

All professionals can screen a user and intervene according to their field of practice.

1.1 Areas meriting attention

Pay particular attention to the following users:

Users 65 and over with:

- A history of stroke or TIA;
- Family history of major neurocognitive disorders;
- Non-stabilized sleep apnea;
- Delirium (evaluation if stabilized for 3 to 6 months);
- Parkinson's Disease or parkinsonism;
- Head trauma (evaluation if stabilized for 3 to 6 months);
- Mild neurocognitive disorder.

Users with:

- A new psychiatric diagnosis after age 50;
- Recurring depressions.

1.2 Complaint from user or friends/family OR clinical suspicion from a professional

"Decline from previous level"

- Change in language and speech;
- Change in memory-related tasks (e.g., forgets to take medication, appointments);
- Psychological and behavioural changes;
- Difficulty recognizing objects or persons;
- Difficulty making decisions;
- Turns to personal attendant to answer questions;
- Inability to carry out ADL, DA or complex activity;
- Unexplained weight loss.

SPECIFICITY: If the purpose of the visit is to renew a driver's licence, begin at points 1.1 and 1.2 and follow the steps, as required.

Questions on cognition (e.g., : AD8[2] OR Dubois five-word test[3] et clock[4] OR MIS[5] and clock OR other quick cognitive tests

If positive screening

If screening is negative

See again in 6 mo.-1 yr. or if there is change.
Emphasize sound living habits,
Promote cognitive health[6], encourage the management of risk factors and inform on the 10 warning signs[7].

If screening is positive

REFER TO A NURSE

Validate telephone number and the availability of the caregiver for an appointment
** If the nurse began a quick test, discuss with the doctor**

2. NURSE'S EVALUATION

*** Accompaniment by a caregiver familiar with the user's routine**

Meeting duration: 60 to 90 minutes

A. Description of the complaint.
B. Evaluate physical condition :
   - Review of medication profile ❷;
   - Physical examination : vision, hearing, language problem, vital signs with BP standing or lying down, quality of sleep, mobility, weight, etc.;
   - Screening: substance abuse (alcohol, drugs).

LEGEND: THE NUMBER INDICATES THE FMG PROFESSIONAL OR THE DEPARTMENT THAT CAN HELP, IF NECESSARY

❶ = Social worker ❷ = Pharmacist ❸ = Community organizations ❹ = Other professionals from or outside FMG

2. NURSE'S EVALUATION - CONTINUED

C. Evaluate mental condition:
- Screening for depression with PHQ-2/PHQ-9[8] OR GDS4;
- MMSE and MoCA based on the INESSS recommendations on page 3[9];
- Personality, behavioural or mood change; if change : NPI-R[10] short version (advised).

D. Uncover the presence of functional issues possibly related to a neurocognitive disorder:
- Available tools to obtain the impressions of the caregiver: QAF[11], IQCODE[12], etc.

E. Family history, psychosocial context, social and family support, etc. (e.g., genogram and ecomap). ❶

F. Determine if known to the CLSC OR home-based care services and request authorization to check out whether the information is relevant (cognitive, functional, social).

G. Begin teaching on the promotion of cognitive health, refer to the local program, if necessary.

Brief discussion with the doctor/front-line specialized nurse practitioner (FLSNP) following an examination of health with anomalies.

3. EVALUATION BY THE DOCTOR AND THE FLSNP[13]

A. Give consideration to the nurse's evaluation.

B. Establish whether confounding factors are present, e.g., medication with a potential effect on cognition ❷, substance use disorder, non-stabilized comorbidity that is metabolic or cardiovascular in origin, etc.

C. Medical history.

D. Physical examination.

E. Decide whether additional investigations are needed (laboratory, imaging).

F. Decide whether additional consultations are needed (e.g., memory clinic, occupational therapist, neuropsychologist, etc.).

3.1 DOCTOR'S DIAGNOSIS ANNOUNCEMENT [13]

NO NEUROCOGNITIVE DISORDER	MILD NEUROCOGNITIVE DISORDER (mNCD) [14] FUNCTIONAL AUTONOMY NOT COMPROMISED	MAJOR NEUROCOGNITIVE DISORDER (MNCD) FUNCTIONAL AUTOMONY COMPROMISED (mild[15], moderate[16], advanced[17] stages)
A. Diagnosis announcement[18] (with the front-line specialized nurse practitioner (FLSCP) (if on the case) to the user in the presence of a caregiver and the nurse or the social worker (if possible). B. Promote cognitive health by encouraging the adoption of healthy living habits (tobacco[19], diet[20], physical activity[21], stress[22], alcohol[23]), the management of risk factors (HTA[24] [G][25], diabetes[26] [G][27]) and support for therapeutic observation.		
	C. Provide information on normal evolution and the next steps. D. Provide the nurse's contact information.	
C. Provide information on the 10 warning signs[28]. D. See the user again, if there's a change.	E. Schedule a nursing and medical appointment the following year or more quickly if there's a change.	**E.** If the medication option[29] is chosen ❷ : • Complete the RAMQ application • Provide info on undesirable effects and contact the nurse if they appear. F. For all users Schedule a follow-up appointment with the nurse within 2 to 4 weeks.

Put the doctor's or specialist's diagnosis on file. Advise the nurse of the information provided, and the reaction of the user and the caregiver. Discuss priority issues for the follow-up.

ENSURE FOLLOW-UP WITH THE USER AND CAREGIVER. CONTINUE WITH FOLLOW-UP

* The process is a help tool. A professional's clinical judgment in deciding the intervention and timeframes take precedence. All proposed tools are for information purposes ***

* Exponent references and the Internet link refer back to the REFERENCES document.