Dementia Care Pearls for Palliative Care & Hospice Teams

UHPCO Annual Convention
November 13, 2019

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Alzheimer’s Association, Utah Chapter
Outline

1. Significance of dementia
2. Brief assessment of cognition
3. Dementia etiologies & key points
4. Approach to behaviors
5. Alzheimer Association & community resources
1. Background/Significance

- Utah: 30,000 people have dementia; projection of 40% more over the next 8 years
- 65-74: 15%, age ≥ 75: 40% have dementia
- Alzheimer: 6th leading cause of death in Utah
- Medicaid costs: $152 million in 2017
- **State action plan** for improved detection, diagnosis, treatment

What stage of dementia do people have when they enter hospice?
## Increase # People with Dementia in Hospice

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>2008</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Alz LOS (days)</td>
<td>57</td>
<td>89</td>
<td>*</td>
</tr>
<tr>
<td>Alz LOS</td>
<td>67</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>Non-Alz #, %, Rank</td>
<td>15,148 4% (10th)</td>
<td>113,204 11% (1st)</td>
<td></td>
</tr>
<tr>
<td>Alz #, %, Rank</td>
<td>12,829 3% (12th)</td>
<td>60,488 6% (6th)</td>
<td>210,000 14% (1st)</td>
</tr>
</tbody>
</table>

*2018 for all diagnoses: US average LOS: 75 days, Utah is longest in country LOS: 99 days*
Predisposing Conditions to Develop Dementia

- Traumatic brain injury
- Stroke
- Parkinson disease
- Diabetes
- Multiple Sclerosis, Autoimmune Disease, ALS
- Trisomy 21

Providers don’t recognize 50% of patients with Alzheimer Dementia
2. Cognition: Diagnosing Dementia

Screening Questions

1. Have you had changes in memory? Is it OK if I ask your loved one about this too?

2. Are you having trouble performing tasks you have done in the past (finances, driving, cooking)?

3. Have you had an accident driving? Are others concerned about your driving?

Address safety issues: wandering, cooking, finances, abuse, driving

Int J Geriatr Psychiatry, 2006;21(4):349-355
2. Cognition: Perform the Mini-Cog

3 item recall and clock drawing task (CDT) - 5 points

- Please listen carefully. I am going to say 3 words that I want you to repeat back to me now and try to remember: (3 unrelated words) village, kitchen, baby. Say them for me now.
- Next I want you to draw a clock for me. First put in all the numbers where they go. (when that is completed) Now set the hands at 10 past 11.
- What were the 3 things I asked you to remember?
- Score: Give 1 point for each recalled word and 2 points for normal clock draw
- Mini-Cog < 3 validated screen for dementia
1. Brief assessment of cognition: Mini-Cog Step 1

Step 1: Three Word Registration

Look directly at person and say, “Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now.” If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies. For repeated administrations, use of an alternative word list is recommended.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Banana</td>
<td>Leader</td>
<td>Village</td>
<td>River</td>
<td>Captain</td>
<td>Daughter</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Season</td>
<td>Kitchen</td>
<td>Nation</td>
<td>Garden</td>
<td>Heaven</td>
</tr>
<tr>
<td>Chair</td>
<td>Table</td>
<td>Baby</td>
<td>Finger</td>
<td>Picture</td>
<td>Mountain</td>
</tr>
</tbody>
</table>

http://www.alz.org/documents_custom/minicog.pdf
Mini-Cog Step 2

Step 2: Clock Drawing

Say: “Next, I want you to draw a clock for me. First, put in all of the numbers where they go.” When that is completed, say: “Now, set the hands to 10 past 11.”

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Clock Drawing

ID: __________ Date: ________________

Circle for clock drawing
Mini-Cog Step 3

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: “What were the three words I asked you to remember?” Record the word list version number and the person’s answers below.

Word List Version: _____ Person’s Answers: ___________________ ___________________ ___________________
Brief assessment of cognition: Mini-Cog Scoring

**Scoring**

<table>
<thead>
<tr>
<th>Word Recall: _____ (0-3 points)</th>
<th>1 point for each word spontaneously recalled without cueing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clock Draw: _____ (0 or 2 points)</td>
<td>Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.</td>
</tr>
<tr>
<td>Total Score: _____ (0-5 points)</td>
<td>Total score = Word Recall score + Clock Draw score. A cut point of &lt;3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of &lt;4 is recommended as it may indicate a need for further evaluation of cognitive status.</td>
</tr>
</tbody>
</table>

Mini-Cog is available free of charge: [http://www.alz.org/documents_custom/minicog.pdf](http://www.alz.org/documents_custom/minicog.pdf)
Clock Drawing Task
Clock Drawing Task
10 After Eyevem
## Activities of Daily Living (ADL)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Score one point for each task that can be done independently</td>
</tr>
<tr>
<td>Dressing</td>
<td><strong>Decreased ADL function is a predictor of hospitalization and death</strong></td>
</tr>
<tr>
<td>Toileting</td>
<td>Intervene to restore function and improve quality of life</td>
</tr>
<tr>
<td>Get out of bed or chair</td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td>Score of 4 = moderate impairment</td>
</tr>
<tr>
<td>Feeding</td>
<td>Score of 2 = severe impairment</td>
</tr>
</tbody>
</table>

Adapted from Gerontologist 10:20-30, 1970
www.ConsultGeriRN.org
Instrumental Activities of Daily Living (IADL)

Score one point for each task that can be done independently

- Using the telephone
- Using transportation
- Grocery shopping
- Preparing meals
- Housekeeping
- Take medications
- Finances
Case Scenario

CP 68 year old referred to hospice-
“His memory is bad, he can’t live alone – needs someone to cook, clean”
TBI 20 years ago – Ask “What has his level of function been?”
What Stage of Dementia Do People Have When Admitted to Hospice?

Functional Assessment Staging Scale (FAST) - *complete on all patients with dementia or suspected dementia*

1. No difficulty, either subjectively or objectively.
2. Complains of forgetting location of objects. Subjective work difficulties.
3. Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity.
4. Decreased ability to perform complex tasks, e.g., planning dinner for guest, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.
5. Requires assistance in choosing proper clothing to wear.
6a: Needs assistance putting on clothes.
6b: Unable to bathe properly.
6c: Inability to handle the mechanics of toileting occasionally or more frequent recently.
6d: Occasional or more frequent urinary incontinence.
6e: Occasional or more frequent fecal incontinence.
7a: Ability to speak limited (1 to 5 words a day)
7b: All intelligible vocabulary lost.
7c: Non-ambulatory.
7d: Unable to sit up independently.
7e: Unable to smile.
7f: Unable to hold head up.

**FAST Stage: 7a**

Disease Specific Criteria for Dementia: FAST 7 and aspiration pneumonia or upper urinary tract infection in past yr (LCD guide)
RT

74 yo man with difficulty with medications, paying bills, missed appointments for the past 6 months– decline in IADLs

He had a stroke 5 years ago, expressive aphasia

Is he eligible for hospice?
What Stage of Dementia Do People Have When Admitted to Hospice?

ALL STAGES!
# 3. Dementia Etiologies & Key Points

## Important Implications of Course & Prognosis (Vary Greatly)

<table>
<thead>
<tr>
<th>Etiology</th>
<th>Percentage</th>
<th>Age at Onset</th>
<th>Prognosis (yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alzheimer</strong></td>
<td>60-80 %</td>
<td></td>
<td>8 – 20 (11.2)</td>
</tr>
<tr>
<td>Cholinergic, Tx: cholinesterase inhibitor (donepezil)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vascular</strong></td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parkinson Disease &amp; Lewy Body</strong></td>
<td>10%</td>
<td>50 and older</td>
<td>5-8</td>
</tr>
<tr>
<td>α-synuclein deposits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frontotemporal</strong></td>
<td>5%</td>
<td>40 - 65</td>
<td>3- 13 (8.7)</td>
</tr>
<tr>
<td>Tau inclusions, serotonin, dopamine, Tx: SSRI</td>
<td></td>
<td></td>
<td>bvFTD with motor neuron disease: 3</td>
</tr>
</tbody>
</table>
Behavior Variant Frontotemporal Dementia with Motor Neuron Disease (MND)

Average survival after symptom onset: 3 years
Examples: Corticobasal degeneration
Progressive supranuclear palsy
Amyotrophic Lateral Sclerosis
# Characteristics of Lewy Body & Frontotemporal Dementia

<table>
<thead>
<tr>
<th>Lewy Body</th>
<th>Frontotemporal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression, Apathy, Anxiety, Agitation</td>
<td>Poor judgment</td>
</tr>
<tr>
<td>Delusions, Paranoia</td>
<td>Loss of empathy</td>
</tr>
<tr>
<td>Fainting, Falls</td>
<td>Socially inappropriate</td>
</tr>
<tr>
<td>Tremor, Rigidity, Muscle spasms</td>
<td>Lack of inhibition</td>
</tr>
<tr>
<td>Poor coordination</td>
<td>Repetitive compulsive behavior</td>
</tr>
<tr>
<td>Muscle weakness</td>
<td>Inability to concentrate or plan</td>
</tr>
<tr>
<td>Inappropriate laughing or crying</td>
<td>Abrupt mood changes</td>
</tr>
<tr>
<td>Swallowing difficulties</td>
<td>Speech difficulties</td>
</tr>
<tr>
<td>Etiology</td>
<td>ICD 10 Code</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
</tbody>
</table>
| Alzheimer’s Disease      | G30.1 and F02.80 or F02.81 | • Gradual onset of symptoms over mo. - yrs.  
• Most prominent feature is memory  
• Impaired learning and recall of recently learned information |
| Vascular Dementia        | F01.50 or F01.51         | • Process information more slowly  
• Stepwise decline  
• May have a hx of stroke r/t cognitive decline |
| Mixed Dementia           | Code predominate etiology first | • Criteria for multiple dementia syndrome etiologies are met; mixed vascular and Alzheimer Disease most common |
| Dementia with Lewy Bodies| G31.83 and F02.80 or F02.80 or F02.81 | • Fluctuating cognition  
• Recurrent visual hallucinations  
• Parkinsonism (bradykinesia, muscular rigidity, tremor, postural instability) |
| Frontotemporal Dementia  | G31.09 and F02.80 or F0281, consider Z55-65 or 91 | • Disinhibition, Apathy, Loss of empathy, Compulsive behaviors,  
• Impaired executive function/decision making |
Treating Behavior Change in Dementia

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Adjunct Professor Neurology and Geriatric Medicine
University of Utah Healthcare

Clarissa Reichmann, PharmD, BCACP, BCGP, CACP
Advanced Clinical Pharmacist
Intermountain Healthcare
## Antipsychotic Medications Commonly Used in Older Adults

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose (PO/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; Generation</td>
<td></td>
</tr>
<tr>
<td>Haloperidol (Haldol®)</td>
<td>0.25-2 mg</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; Generation (Atypical)</td>
<td></td>
</tr>
<tr>
<td>Risperidone (Risperdal®)</td>
<td>0.25-2 mg</td>
</tr>
<tr>
<td>Aripiprazole (Abilify®)</td>
<td>2-10 mg</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa®)</td>
<td>2.5-7.5 mg</td>
</tr>
<tr>
<td>Quetiapine (Seroquel®)</td>
<td>12.5-150 mg</td>
</tr>
</tbody>
</table>

Courtesy of Dr. Martin Freimer
## Comparison of Antipsychotic Side effects

<table>
<thead>
<tr>
<th>Drug</th>
<th>Weight Gain, Hyperglycemia, ↑ triglycerides</th>
<th>EPS/TD</th>
<th>Sedation</th>
<th>Anticholinergic Side effects</th>
<th>Orthostatic Hypotension</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Generation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol (Haldol®)</td>
<td>+</td>
<td>+++</td>
<td>++</td>
<td>-/+</td>
<td>-</td>
</tr>
<tr>
<td><strong>2nd Generation (Atypical)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risperidone (Risperdal®)</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Aripiprazole (Abilify®)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa®)</td>
<td>+++</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Quetiapine (Seroquel®)</td>
<td>+++</td>
<td>-/+</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
</tbody>
</table>

*Courtesy of Clarissa Reichmann, PharmD*
### Other Psychotropic Medications Commonly Used in Older Adults

<table>
<thead>
<tr>
<th>Pharmacologic Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td>Lorazepam (Ativan®)</td>
</tr>
<tr>
<td></td>
<td>Alprazolam (Xanax®)</td>
</tr>
<tr>
<td></td>
<td>Diazepam (Valium®)</td>
</tr>
<tr>
<td></td>
<td>Clonazepam (Klonopin®)</td>
</tr>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitors (SSRI)</strong></td>
<td>Sertraline (Zoloft®)</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine (Prozac®)</td>
</tr>
<tr>
<td></td>
<td>Paroxetine (Paxil®)</td>
</tr>
<tr>
<td></td>
<td>Citalopram (Celexa®)</td>
</tr>
<tr>
<td></td>
<td>Escitalopram (Lexapro®)</td>
</tr>
<tr>
<td><strong>Serotonin- Norepinephrine reuptake inhibitors (SNRI)</strong></td>
<td>Duloxetine (Cymbalta®)</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine (Effexor®)</td>
</tr>
<tr>
<td></td>
<td>Desvenlafaxine (Pristiq®)</td>
</tr>
<tr>
<td><strong>Mood stabilizers</strong></td>
<td>Lithium (Lithane®)</td>
</tr>
<tr>
<td></td>
<td>Valproic Acid (Depakote®)</td>
</tr>
<tr>
<td></td>
<td>Carbamazepine (Tegretol®)</td>
</tr>
</tbody>
</table>
Behavioral Side Effects

• “Slow the Brain Down”
  • Harder to make sense of surroundings, frightening
    o Increase anxiety, agitation, aggression
  • Common contributing medications: Benzodiazepines, anticholinergic medications, sedating antipsychotics, mood stabilizers

• “Increase irritation”
  • Common contributing medications: SSRIs, Risperidone, Haloperidol

Courtesy of Dr. Martin Freimer
Antipsychotic Side Effects

- Sedation
- Confusion, delirium, cognitive worsening
- Worsening psychotic symptom
- Orthostatic hypotension
- Parkinsonian side effects
- Urinary retention/constipation
- Weight gain/hyperglycemia/diabetes/increased triglycerides
- Increased fall risk!

Courtesy of Dr. Martin Freimer
Antipsychotic use and Fall Risk

• Antipsychotics can:
  o Worsen Parkinson’s motor symptoms (rigidity, slowness)
    ▪ Haloperidol (Haldol®), Aripiprazole (Abilify®), Olanzapine (Zyprexa®)
    ▪ Quetiapine (Seroquel®)- less likely
  o Cause orthostatic hypotension
    ▪ Quetiapine (Seroquel®)

These side effects are worse in the patient with Parkinson Disease and Lewy Body Dementia!

Courtesy of Dr. Martin Freimer
**What Should You Do When You Recognize a Behavior Change?**

**SBAR Communication**

The nurse will report the behavior change to the health care provider using SBAR

- Situation – what is the change?
- Background – details about the change and other circumstances that might be impacting the change
- Assessment – the nurse’s assessment of the patient/resident (physical, mental, environment)
- Recommendation – what will be done next

The information reported by CNA, CG to the nurse helps him/her provide the appropriate information about the behavior change

**SBAR for Nurses**

<table>
<thead>
<tr>
<th>S</th>
<th>B</th>
<th>A</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation</td>
<td>Background</td>
<td>Assessment</td>
<td>Recommendation</td>
</tr>
</tbody>
</table>

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RegisteredNurseRN.com
Responding to a Behavior Change

• Did the patient experience something upsetting? Pain, Change in environment
• Was a new medicine started prior to the behavior? Within hours? Days?
  o A medication doesn’t have to be for “behavior” or “psychiatric” to contribute to behavior change
  o “if it can get in the brain it can affect the brain”
• What happens when more of the same medicine is given?
  o Does the behavior intensify?
  o Is it more frequent?

Sometimes, the solution is less medicine not a new medicine or more of the same

Courtesy of Dr. Martin Freimer
Behaviors NOT treated by antipsychotics

- Wandering
- Restlessness
- Nervousness
- Impaired memory
- Insomnia
- Poor self care

- Fidgeting
- Mild anxiety
- Inattention or indifference to surroundings
- Uncooperativeness without aggressive behavior
- Sadness or crying alone that is not related to depression or another psychiatric disorder

Courtesy of Dr. Martin Freimer
Behaviors that **MAY** warrant the use of Antipsychotics

**Severely aggressive behavior**
- Especially physical aggression
- Danger to the person or others

**Hallucinations**
- If distressing the individual

**Delusions**
- Note: memory problems are often mistaken for delusions
  - e.g., thinks people are stealing items
- Also consider vision & hearing problems

**Schizophrenia**

**Severe mood disorders**

**Not responding to non pharmaceutical therapies**

**Significant decline in function**

**Substantial difficulty receiving needed care**

**Possibly other distressing agitations**

Courtesy of Dr. Martin Freimer
1. Rule out reversible causes prior to using a medication
2. Try non-pharmacologic management strategies first
3. Clearly document treatment targets (symptoms) before and after a treatment strategy is tried
4. Justify the use of an antipsychotic
5. Consider the impact of side effects on comorbidities when choosing a medication and start with a low dose
6. If the medication doesn’t help within 4 weeks, stop it
   Use appropriate tapering strategies.
7. In patients who respond to the drug, an attempt to taper and withdraw the drug should be made within 4 weeks of starting

Courtesy of Dr. Martin Freimer
Patient Case

DL is a 74 yo female with moderate Alzheimer’s Disease. Her children report that she has been more agitated lately. They are wondering if they could “get something” to help with her outbursts when they are assisting her around the house. Her current medications are as follows:
DL’s Medication List:

- Acetaminophen 325 mg Q 4 H PRN Pain
- Apixaban 2.5 mg BID
- Atorvastatin 40 mg daily
- Donepezil 10 mg QHS *
- Fluoxetine 40 mg daily *
- Lisinopril 20 mg daily
- Omeprazole 20 mg daily
- Tylenol-PM (diphenhydramine)*

Courtesy of Dr. Martin Freimer
References/Resources

- The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis In Patients with Dementia. Reus VI et al. AM J Psychiatry. (2016)

- Lexicomp Online. Copyright © 1978-2019 Lexicomp, Inc. All Rights Reserved.


Approaches cont’  Aggression and Agitation, Triggers and What Helps

Triggers

- when they can't remember or can't do the steps (involved in daily activities)
- when they don't recognize the person caring for them. “If a person they can't recall having met comes into the room, escorts them to the bathroom and then starts pulling down their pants, you can imagine that can be alarming”
- Constipation, urinary retention

Meta-analysis: identified nearly 20,000 earlier studies that evaluated the effectiveness of nonpharmacological therapies, narrowed that down to 163 studies - 23,143 patients, average age was 70

- physically aggressive patients - outdoor activities more effective than antipsychotics
- verbal aggression/agitation - massage and touch therapy were more effective than the patients' usual care

Watt et al., Annals Int Med, Oct 2019
Dementia Pearls

1. Screen pt & cg - Recognize cognitive limitations
2. Address safety issues, use team approach
3. Refer: alz.org, eldercare.acl.gov
4. Use dementia etiology info to inform caregivers re: behavior, progression, prognosis, hospice eligibility - FTD with motor neuron disease
5. Pharm consult, med optimization, decrease anticholinergic burden, improve cognition
6. Review medical record: cog eval, brain CT or MRI scan, diagnoses
7. Wt loss, GI, other end of life changes - increase or decrease med effects
8. How do caregiver/environment match person and their needs?
9. Adjustment to change takes time: 3 days, 1-3 months, never
10. ASK: What’s most important?
Alzheimer's Disease and Related Dementias (ADRD) Online Education Program

Four modules to increase knowledge about ADRD and improve care of residents with dementia. These modules are designed for patients, family members, and direct care workers employed in long-term services and supports (LTSS).

1. Overview of dementia
2. Effective communication
3. Understanding behaviors and your approach
4. Communication and understanding behaviors

Along with the covered topics, each module includes a case study of "Mrs. Jones" that is used to demonstrate the skills and techniques raised in each module. Participants will be asked to complete an anonymous survey both before and after completion of the modules.

To get started, visit utahgwp.org/trainings/dementia-training

This work was funded by the Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) grant number U1QHP28741 Geriatrics Workforce Education Program (GWEP)

University of Utah College of Nursing
Resources/References

Alzheimer’s Disease and Other Dementia Coordinating Council, Utah Dept. of Health


Int J Geriatr Psychiatry, 2006;21(4):349-355


Watt et al., Ann Intern Med Oct, 2019

Cherie.Brunker@imail.org
Dementia Care Resources

UHPCO Annual Convention
November 13, 2019

Mark Dixon, Program Director
Alzheimer’s Association, Utah Chapter
Session Objectives

By the end of this session, participants will be able to:

- Describe the impact of dementia for patient caregivers and the importance of patient caregiver support
- Locate contact information for local Area Agency on Aging and other community supports
- Identify local resources for respite care
There **IS** Extraordinary Stress Inherent In The Caregivers’ Role

- The person receiving care may outlive the caregiver
- Often overwhelmed with doubts: “Am I doing enough?”
- They can become isolated, and anxious with their circumstances
- They are your “silent patients”
1. Denial
2. Anger
3. Social withdrawal
4. Anxiety
5. Depression
6. Exhaustion
7. Sleeplessness
8. Irritability
9. Lack of concentration
10. Health problems
10 Tips For Caregivers To Manage Stress

1. Take a break
2. Seek community resources
3. Become an educated caregiver
4. Get help/find support
5. Take care of your health
6. Manage stress levels
7. Accept changes as they occur
8. Make legal/financial plans
9. Know that you are doing your best
10. Visit your doctor regularly
Alzheimer’s Association
Caregiver Support
Resources

- Wide variety of printed materials
- ALZ.org
- Community education
- Caregiver support groups
  (800) 272-3900
Alzheimer’s Association Healthcare Provider Resources

- Smart Phone App
- Cognitive Assessment Toolkit
- Care Planning Resources
- CME Opportunities
- Physician Outreach Webinars
- Resources “Thumb Drive”
Other Caregiver Support Resources

- Local Area Agency on Aging (AAA)
- University of Utah’s Center For Alzheimer’s Care, Imaging, and Research (CACIR)
- Community Resource Finder (www.communityresourcefinder.org)
Other Caregiver Support Resources (cont.)

- Local Area Agency on Aging (AAA)
- University of Utah’s Center For Alzheimer’s Care, Imaging, and Research (CACIR)
- Community Resource Finder (www.communityresourcefinder.org)
- Other Resources as they are developed
To promote positive aging and assist older adults in maintaining health, independence, & quality of life

Information & resources Advocacy
Plan, coordinate, and provide services

https://eldercare.acl.gov/
Welcome to the Eldercare Locator, a public service of the U.S. Administration on Aging connecting you to services for older adults and their families. You can also reach us at 1-800-677-1116.

Have A Question?
Speak with an Information Specialist
Monday - Friday
9am - 8pm ET
- Start an Online Chat

Caregiver Corner
Visit our Caregiver Corner for
AAA Services

Information & Resources
Caregiver Support Program
In-Home Services Programs
Evidence-Based Dementia & Health Programs
Nutrition
Medicare Insurance Counseling
Long-term Care Ombudsman
And so much more ...

https://eldercare.acl.gov/
Education & Training

Caregiver Education & Training
• Caregiver Academy
  (6 week series offerings throughout Utah)

Dementia Related Training & Education
• Stress Busters
• Rosalyn Carter Institute: RCI REACH
  (1:1 counseling)
• Rosalyn Carter Institute: Dealing with Dementia
  (4 hour community workshop)
• Dementia Live
• Dementia Dialogues
Other Services

- **Options Counseling**
  Assists individuals and families in identifying long-term support and services.

- **Veteran Benefit Counseling**
  Identify eligibility of VA benefits and programs, provide information, and assists clients with enrollment.

- **H.E.A.T.**
  One-time-per-season financial assistance with fuel and power bills.

https://eldercare.acl.gov