



UNDERSTANDING THE EARLY STAGE OF DEMENTIA FOR AN INTERPROFESSIONAL TEAM

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Age-Friendly Care and Health Systems



Age-Friendly Care is evidence-based, causes no harm, and aligns with What Matters to older adults and their caregivers (IHI, 2019).



The RI-GWEP endorses and supports age-friendly care.

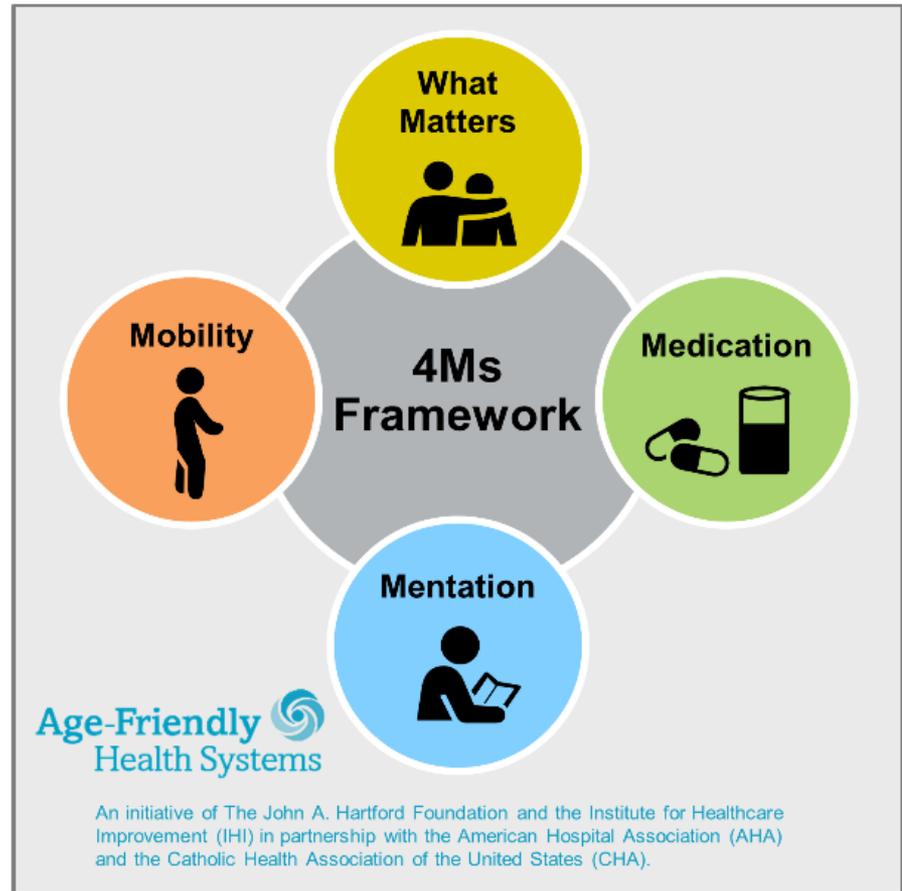


RI-GWEP programs are guided by the '4M Framework'.

The 4M Framework:

- Guided by an essential set of evidence-based practices
- Practice tested
- Causes no harm
- Improves outcomes
- Used reliably across settings
- Able to be adapted locally

* [1]. Hartford Foundation, American Hospital Assoc., Catholic Health Assoc. [2].



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Age-Friendly Health Systems

4Ms:
What Matters, Medication,
Mentation, Mobility

Assess

Know about the 4Ms
for each older adult
in your care

Act On

Incorporate the 4Ms into
the plan of care

Learning Objectives

Following completion of this course, attendees will be able to:

1. Describe hallmark signs of early-stage dementia.
2. List changes in cognitive status that are typical of early-stage dementia.
3. Identify common manifestations that arise during early-stage dementia.
4. Identify common issues that arise during early-stage dementia.
5. Describe general strategies for managing symptoms of dementia.



Outline 2- Introduction



- Introduction
- Manifestations of early-stage dementia:
 - Overview
 - Alzheimer's disease (AD)
 - Vascular dementia (VaD) (and vascular cognitive impairment [VCI])
 - Lewy body dementia (LBD)
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- Addressing common manifestations and care partner issues of early-stage dementia

Introduction

- Dementia involves progressive deterioration of cognitive and functional abilities.
- Staging of dementia can provide information and the framework for medical and psychosocial care needs.
- People with early-stage dementia remain independent and generally retain much of their cognitive functioning but can have impairments in cognitive and executive functioning that interfere with their daily activities.
- Behavioral and psychological symptoms of dementia (BPSD) are important components of dementia with substantial consequences to the older adult and care partner (Kales et al, 2014).



Dementia as the Organizing Principle of Care

- Dementia affects every aspect of a person's life (Lazaroff et al., 2013)
- Most persons living with dementia (PLwD) are managed in primary care practices (Hogan et al., 2008).
 - Many PLwD live at home as long as possible.
- There is no cure for dementia; progressive mental and cognitive decline is inevitable (Apesoa-Varano et al., 2011).
- Historical biomedical emphasis on “cure” is not appropriate for dementia—it has been replaced with focus on “caring” by interprofessional team (Apesoa-Varano et al., 2011; Hogan et al., 2008) and on maximizing or sustaining function and quality of life.

Treatment Goals

- Treatment goals (Lazaroff et al., 2013):
 - Provide symptom relief.
 - Minimize negative effects of dementia on persons living with dementia and care partners.
 - Maximize functional independence of the persons living with dementia.
 - Manage behavioral, psychosocial, and safety issues that may arise.
 - Optimize management of comorbid conditions.
 - Provide guidance and support for care partners.
- When possible, integrate the subjective experiences of the PLwD into the treatment plans (Zwijssen et al., 2016).

Treatment Goals



Focus on well being

- Reduce or eliminate environmental stressors
- Provide positive distractions
- Enable social support
- Give a sense of control

A New Paradigm

- What if we defined Dementia in the language of disabilities?
 - Individuals respond to their disease according to how supportive their environments are
 - Careful focus on the utilization of those capacities that remain – particularly psychological capacity
 - A shift in the way the person experiences the world around him/her
 - Person-centered & individualized
 - Our job is to “build ramps”





Outline 3- Manifestations of early-stage dementia overview



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What have you heard?



October 23, 2019

Could taking statins prevent dementia, disability?



The artificial sweetener aspartame can cause Alzheimer's.

You can prevent Alzheimer's disease by brain training.



Smelling peanut butter can help diagnose Alzheimer's.

“Creamy or crunchy — and oh, so spreadable — peanut butter is . . . a possible game-changer in Alzheimer’s disease research,” began a 2015 post on the Cleveland Clinic website. That claim, based on

Manifestations of Early-Stage Dementia: Overview

- Dementia is characterized by cognitive and executive function impairments that eventually lead to loss of ability to perform ADL (Verlinden et al., 2016).
- Initially, PLwD generally retain a fair degree of cognition, capabilities, and personality (Stewart, 2012).
- Memory impairment is influenced by type of dementia (Schubert et al., 2016) and location of brain cell damage (Kuceyeski et al., 2011).
 - Initial memory impairment occurs in short-term/working memory and semantic memory (Wilson et al., 2011).

Where are my ?????!!!!



Living with
and Mitigating
Frustration





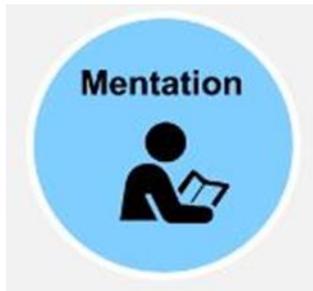
Manifestations of Early-Stage Dementia: Overview (continued)

- Other impairments may result from normal aging, progressive damage to the brain (Roberts et al., 2016) and type of dementia (Auning et al., 2011; Possin, 2010; Roberts et al., 2016).
- PLwD have difficulties first with IADL before losing ability to perform basic ADL (Verlinden et al., 2016).
- Persons with early-stage dementia may also manifest Behavioral and psychological symptoms of dementia (BPSD) (Aarsland et al., 2014; Desai et al., 2012; Kales et al., 2015).
 - Care partners do not usually notice or report substantial changes in the personality of PLwD (Stewart, 2012).

Cognitive and Executive Functioning Impairments

Beginning in early-stage and throughout the course of dementia, there is continued and progressive decline in:

- Memory and executive functioning (Galvin, 2012; Giebel et al., 2015)
- Functional impairments
- Impairments in language skills, visual perception, ability to focus and pay attention
- Ability to perform IADL



If it were you?!

Visuoperceptual Difficulties

- Causes of visuoperceptual difficulties such as problems with depth perception, sharpness, and loss of peripheral vision, problems adapting to changes in light levels, and impairments in audio-visual speech capabilities:
 - Normal aging is associated with structural and functional changes in vision, hearing, and perceptual acuity (Alm et al., 2013; Chang et al., 2015; Eichenbaum, 2012; Huyse et al., 2014; NEI, 2011).
 - Dementia adds progressive damage to the brain.
- Each type of dementia can affect visuoperceptual abilities differently (Caputi, et al., 2015; Diaz-Santos et al., 2015; Paxton et al., 2007; Wood et al., 2013).



Issues and ideas:

What have you seen or experienced?

Behavioral and Psychological Symptoms of Dementia

- Behavioral and psychological symptoms of dementia (BPSD) occur across all stages of dementia; type and prominence depend on the stage and individual considerations of the PLwD (Aarsland et al., 2014; Desai et al., 2012; Kales et al., 2015).
- BPSD are among the most complex symptoms to manage, particularly during the later stages of dementia (Kales et al., 2014; Lyketsos et al., 2011).
- BPSD cause significant suffering to PLwD and their care partners. They are a predominant (if not primary) cause of (premature) institutionalization (Kales et al., 2014).

Meet Uncle Lenny

Uncle Lenny lived on his own with his little dog, Lucy. His wife Rita's death in Florida. He kept his own schedule, got his own meals and had friends in the community. On any given day he would get breakfast at a local diner where he saw friends, go to the senior center to watch the baseball game and have lunch and spend the afternoon at various outings-always with his dog. He was quite content until an infection landed him in the hospital. He came home after that episode, but not long after became sick and was again hospitalized. This time though, he was discharged to a local nursing center. The following are scenarios described by Uncle Lenny.



What do you think?

Your assignment

- Imagine you are Uncle Lenny:
 - What's going on from your viewpoint?
 - How are you feeling?
- Imagine you are a care giver:
 - What's going on from your viewpoint?
 - How are you feeling?

It's a Mad, Mad World

Uncle Lenny's day now consists of sitting in a large multi-purpose room with 27 other residents. Music blares from a TV on the wall, unhappy residents call out and CNAs watch and intervene. He and the others spend their day there-all day. He frequently talks about "breaking out." Uncle Lenny needs to stretch and adjust his pants. As he stands up to do so, several aides in the room quickly close in on him, telling him to sit down. Uncle Lenny tells me that there is a conspiracy of some kind happening. They will not let you leave, you are never to be alone and he says wryly "watch this"! If you stand up, the staff instantly runs over to make you sit down. They can never give a good reason why you must sit.

Discussion

- Imagine you are Uncle Lenny:
 - Describe what's going on from your viewpoint.
 - Describe how you are feeling.
- Imagine you are a care giver:
 - Describe what's going on from your viewpoint
 - Describe how you are feeling.

WHOSE WORLD IS REAL?

It's a Mad, Mad World

Uncle Lenny tells me he has been robbed. All of his pants with a fly and belt have been taken and replaced with these cheap things that are “not for a man.” His button up shirts with a pocket have disappeared, too. He frequently drops his glasses on the floor, so they stopped giving them to him. He says it's hard for him to remember that he no longer has a pocket in his shirt. It is the only kind of shirt he has worn all his life. As a result, he can't read the paper—a key part of his daily routine. Uncle Lenny says his personal items have also been taken. He wants his cell phone so that he can call the police and save the lives of the people in the room. He no longer has a wallet. He had one all his life, and had it when he came, but it is now gone. He strongly believes it is their attempt to keep him from escaping.

Discussion

- Imagine you are Uncle Lenny:
 - Describe what's going on from your viewpoint.
 - Describe how you are feeling.
- Imagine you are one a care giver
 - Describe what's going on from your viewpoint
 - Describe how you are feeling.

WHOSE WORLD IS REAL?



In Loving Memory
Leonard Mournighan
June 7, 2014



Outline 4 - Manifestations of early-stage dementia



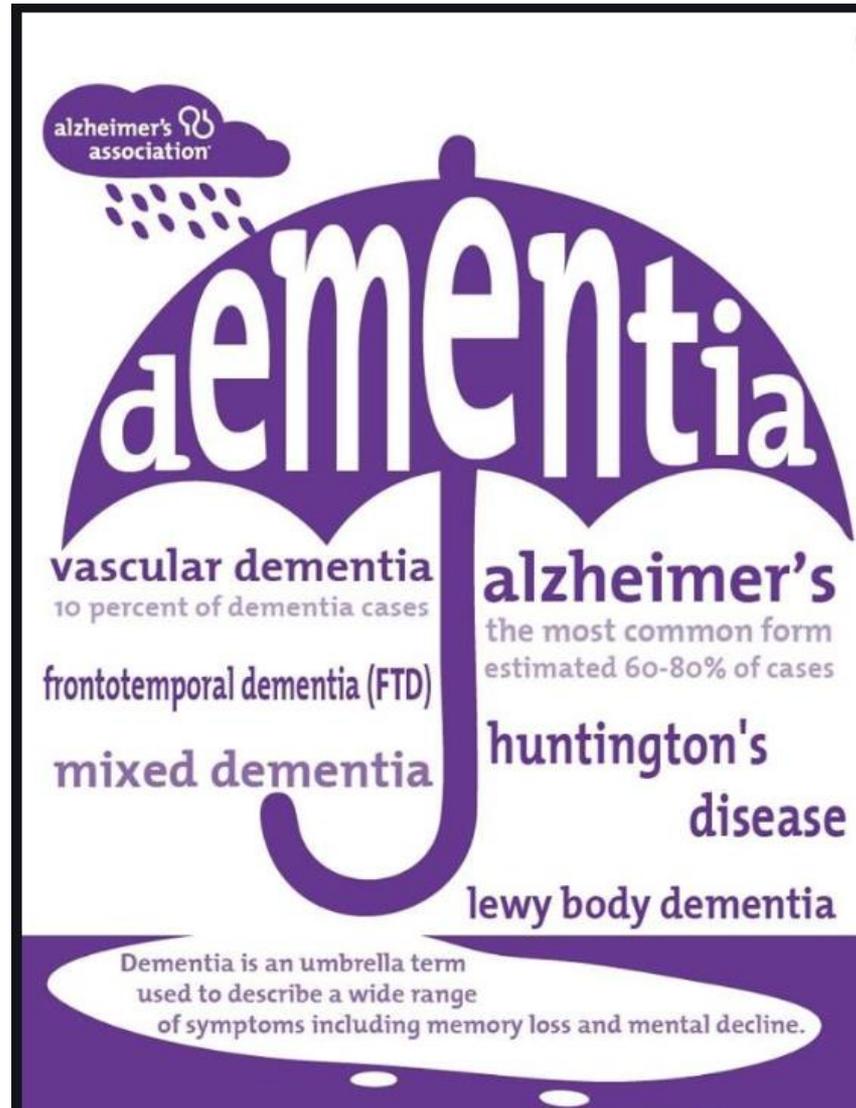
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Early-Stage Alzheimer's Disease: Clinical Manifestations

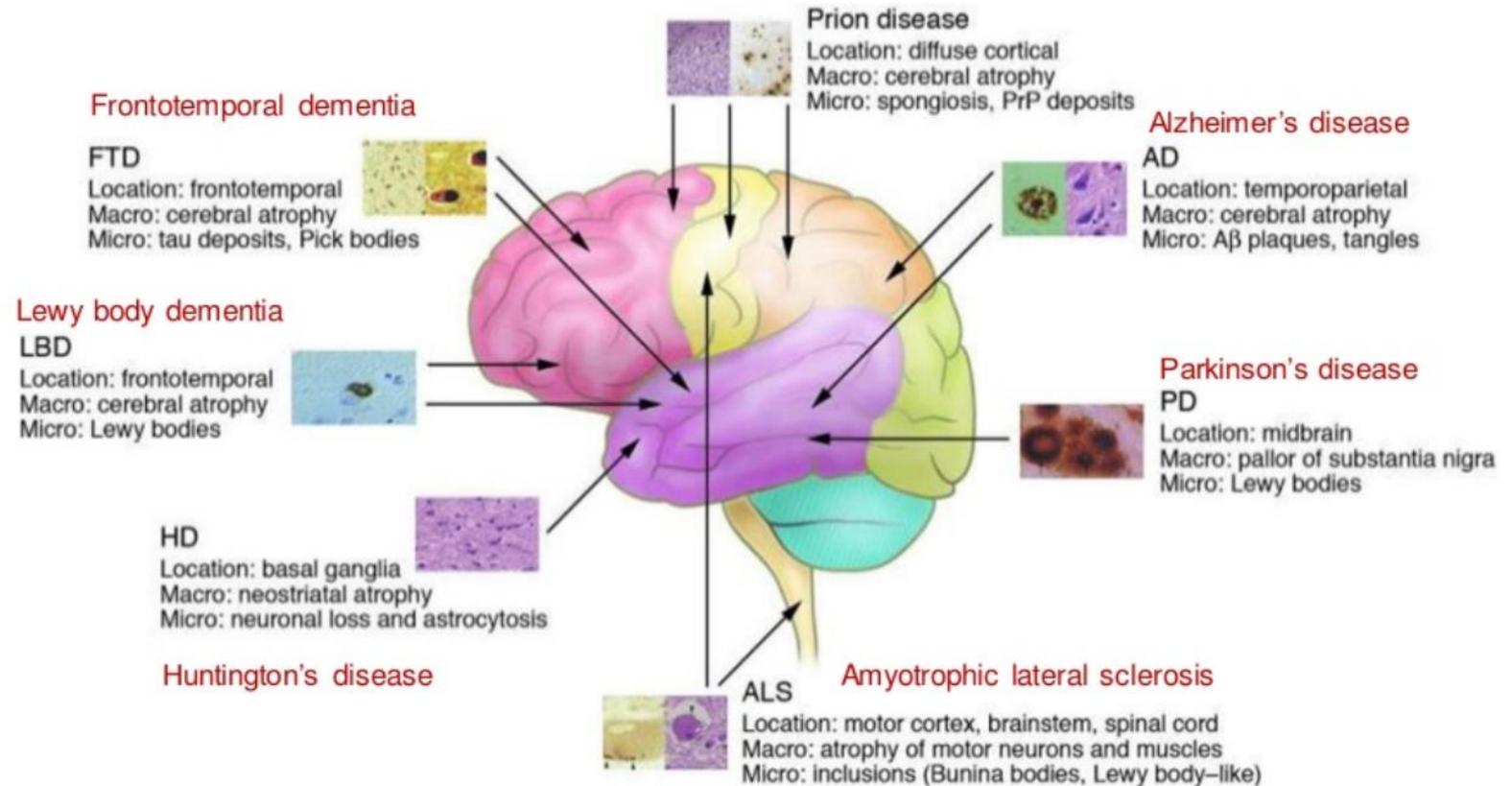
- Early-stage Alzheimer's disease is characterized by mild to moderate decline in memory (Galvin, 2012; Giebel et al., 2015; Godefroy et al., 2016), executive functioning, visual-spatial issues, and the emergence of BPSD (Galvin, 2012; Godefroy et al., 2016; NIA, 2017e).
- Executive dysfunction is common in early stages of Alzheimer's disease (Godefroy et al., 2016).
 - Decreased ability to plan and organize (Giebel et al., 2015; Godefroy et al., 2016)
 - Difficulties completing tasks and with IADL (Liu-Seifert et al., 2015; NIA, 2017e)
 - Problems finding words in speaking or writing (NIA, 2017e)
 - Becoming lost or disoriented in familiar places
 - Impairments in judgment and reasoning (NIA, 2017e)
 - Withdrawal from work or social activities (Galvin, 2012)
 - Changes in mood or personality (depression, apathy) (Galvin, 2012; Godefroy et al., 2016; NIA, 2017e)



Dementia Syndrome?



Selected areas of change: macroscopic and microscopic

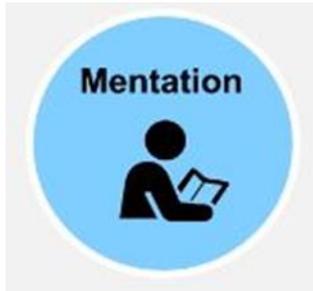


Lars Bertram and Rudolph E. Tanzi, "The genetic epidemiology of neurodegenerative disease", **2005**, *J Clin Invest.* 115(6):1449

Factors Influencing Rate of Progression in Alzheimer's Disease

- AD course is progressive, but rate varies widely among individuals.
- There are 2 common approaches to define "rapid cognitive decline" (Arevalo-Rodriguez et al., 2015; Aubert et al., 2015).
- Factors associated with slower rate of decline (Aubert et al., 2015; Galvin, 2012; Williams et al., 2010):
 - Diet, cognitive abilities/reserve, physical activity, social/leisure activities
- Factors associated with more rapid decline (Aubert et al., 2015; Galvin, 2012; Williams et al., 2010):
 - Older age, comorbidities
 - Initiating anticholinergic medications (Carriere et al., 2009; Shah et al., 2013)
- Vascular factors (e.g., hypertension, hypercholesterolemia) are not significantly associated with AD progression (Galvin, 2012; Williams et al., 2010).

On the Sunny side of the Street



Early-Stage Vascular Dementia

- VaD encompasses numerous etiologies that can manifest with different clinical features (Karantzoulis et al., 2011; Roh et al, 2014).
- Signs and symptoms depend on:
 - Area(s) of brain affected (Gorelick & Nyenhuis, 2013; Sahathevan et al., 2012)
 - Presence or absence of underlying conditions
 - Volume/location of underlying pathology (Gorelick & Nyenhuis, 2013)
- VaD can have both focal neurocognitive deficits based on location of stroke lesions or a more diffuse (global) pattern (Karantzoulis et al., 2011).
- Post-stroke vascular dementia can also manifest with physical impairments.

Clinical Manifestations of Early-Stage VaD

- Executive dysfunction: A “hallmark” of vascular cognitive impairment (VCI) but is not specific to cerebrovascular disease
- Similarities and differences between vascular dementia (VaD) and AD:
 - Memory deficits less overt than in AD (Gorelick & Nyehius, 2013; Gorelick et al., 2011; Karantzoulis et al., 2011)
 - Personality changes and loss of social skills
 - Possible mild visuospatial deficits with subcortical VaD as with AD (Karantzoulis & Gavin, 2011)
 - Affective disturbances common in VaD (Karantzoulis & Gavin, 2012; Mayo Clinic, 2018)

Clinical Manifestations of Early-Stage VaD (continued)

- Sensory impairments include slurred speech and language problems (Mayo Clinic, 2018).
- Hallucinations and delusions may be present (Mayo Clinic, 2018).
- However, there is no evidence that vascular risk factors have a causal effect on dementia in either Alzheimer's disease or VCI (Sahathevan et al., 2012).

Early-Stage Lewy Body Dementia (LBD): Overview

- LBD encompasses dementia with Lewy bodies (DLB) and Parkinson's Disease Dementia (PDD).
- Defining features of LBD include cognitive impairment, motor Parkinsonism, behavior and mood changes, plus alterations in sleep and autonomic function (Aarsland, 2016).

Early-Stage Lewy Body Dementia (LBD): Overview (continued)

- DLB and PDD share many clinical and pathological similarities and are sometimes considered as different points on a spectrum (Aarsland, 2016; Connolly & Fox, 2014).
 - PDD is characterized by a period of pure motor symptoms first; cognitive symptoms develop more than a year after onset of movement problems (Aarsland, 2016; Miller & Boeve, 2011).
 - DLB occurs in older adults, who develop before or around the same time as motor symptoms (Connolly & Fox, 2014) and is often associated with a more severe course than PDD (Aarsland, 2016).
- LBD rate of decline is much faster and its survival time is shorter compared with AD (Aarsland, 2016).
- Greater impairments are associated with DLB than with PDD (Jicha et al., 2010; Yoon, et al., 2014).

Early-Stage LBD: Clinical Manifestations

- Marked attentional and executive function disorders are present in LBD with significant cognitive fluctuations (Karantzoulis et al., 2011; Lee et al., 2012).
- Rapid eye movement (REM) behavioral disorder (RBD) is a sleep difficulty predominantly associated with LBD (Karantzoulis et al., 2013; Mayo Clinic, 2018).
- Mild cognitive impairment (MCI) is present at the time of PD diagnosis in about one-third of individuals and in approximately half of all older adults afflicted with nondemented Parkinson's disease after 5 years (Aarsland, 2016; Connolly et al., 2013).
- Hallucinations are among the most common core features of DLB prior to the initial evaluation, followed by Parkinsonism and cognitive fluctuations (Auning et al., 2011).

LBD Versus Alzheimer's Disease

LBD and Alzheimer's disease have some similarities and numerous differences (Auning et al., 2011; Karantzoulis et al., 2011). Compared with persons with Alzheimer's disease, persons with LBD are:

- More likely to have psychiatric symptoms and more functional impairments at time of diagnosis (Connolly et al., 2013; Grover et al., 2015; Karantzoulis & Galvin, 2011)
- More likely to have sleep disturbances, cognitive fluctuations, well-formed visual hallucinations, and muscle rigidity or Parkinsonian movement problems early in the disease (ACT on Alzheimer's, 2012; Auning et al., 2011)
- Likely to have pronounced visuospatial impairments in LBD that appear earlier in the disease course (Karantzoulis et al. 2012)
- Memory may be relatively intact in early LBD; in later stage disease, LBD is harder to differentiate from AD (Karantzoulis et al., 2011)
- More likely to have nonmotor behavioral symptoms (Aarsland, 2016; Grover et al., 2015; Wood et al., 2010)

Early-Stage Frontotemporal Degeneration (FTD): Overview

- FTD is a heterogeneous group of diseases with overlapping clinical symptoms but different causative genes and differing underlying pathologies (Lashley et al., 2015; Riedl et al., 2014).
- FTD is caused by damage to frontal and/or temporal lobes (Piguet et al., 2011). Impairments generally progress quickly but memory often remains intact.
- Distinctive clinical syndromes, with heterogeneous neuropathology (NIA, 2017b):
 - Progressive behavior/personality decline (Borroni et al., 2015; Mioshi et al., 2010)
 - Progressive language decline: Primary progressive aphasia (PPA) initially language related (Kremen et al., 2011; Mioshi et al., 2010; Piguet et al., 2011)
 - Progressive motor decline (less common) (NIA, 2017b)

Early-Stage Frontotemporal Degeneration (FTD): Overview (continued)

- Persons with FTD demonstrate changes in behavior and personality, language problems, and motor problems (Ferrari et al., 2011; NIA, 2017b; Piguet et al., 2011).
- Memory impairment is minimal in early stages (Arlt, 2013; Schubert et al., 2016).

Behavioral Variant Frontotemporal Degeneration (bvFTD): Clinical Manifestations

- FTD is a progressive disorder with no clear indications of transition points between stages (Borrioni et al., 2015; Mioshi et al., 2010).
- Persons with early stage bvFTD have (Borrioni et al., 2015; Mioshi et al., 2010, NIA, 2017b):
 - Substantially greater functional and behavioral changes compared with PPA (Mioshi et al., 2010).
 - Marked variability in initial symptomatic presentations (Karantzoulis et al., 2011).
 - Behavioral manifestations (NIA, 2017b).
- PPA is characterized by progressive language decline, including impaired ability to speak, understand, read, and write (NIA, 2017b) and impairments to knowledge regarding meaning of words and objects (Karantzoulis & Galvin, 2011).
- FTD is associated with progressive motor decline: movement problems/slowed movement, muscle rigidity (Parkinsonian symptoms), body stiffness, changes in behavior or language.
- Binge eating habits are possible (Ferrari et al., 2011; Piguet et al., 2011)

Early-Stage Behavioral Variant Frontotemporal Degeneration (bvFTD): Unique Concerns

- Disinhibition (Laforce, 2013)
- Sexuality concerns:
 - Hypersexual behavior may be early manifestation of bvFTD (Mendez & Shapira, 2013).
 - Sexuality concerns may affect up to 18% of older adults with bvFTD.
 - Studies suggest either hypersexuality or hyposexuality in early-stage bvFTD (Ahmed et al., 2015).
- Early driving concerns:
 - There are few studies on PLwD not associated with AD.
 - Older adults with FTD are more likely to show dangerous driving behaviors in early stage compared with older adults with AD (Fujito et al., 2016).

Early-Stage Behavioral Variant Frontotemporal Degeneration (bvFTD): Unique Concerns (Continued)

- Criminality:
 - New onset criminal behavior may be early manifestation of bvFTD or sFTD.
 - Theft, traffic violations, sexual advances, trespassing, and public urination may be evident (Liljegren et al., 2015).



Outline 5 - General strategies to address manifestations of dementia



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General Strategies

- There are many general strategies that a provider or care partner can use to help manage behavioral and psychological symptoms of dementia (BPSD) (Cohen-Mansfield et al., 2015; Kales et al., 2014, 2015; Nordgren et al., 2014).
 - Patient engagement
 - Physical activity
 - Communication
 - Sensory stimulation
 - Environmental changes
 - Task simplification
 - Guidance for care partner
- Nonpharmacologic versus pharmacologic interventions
 - Cognitive stimulation

A Day in the Life

Philosophy of care focused on well being – finding and holding the Comfort Zone

Being fluent in Alzheimer's

Drug free/minimal

Personalized interventions

Reduced Noise

Shift Change

Redefined “activity”

A process to enhance sleeping & waking

Restructured bathing

Engaging Persons Living with Dementia

- Contributes to greater sense of well-being (Smit et al., 2016)
- Person-centered care approaches (Edvardsson et al., 2013; Keating et al., 2012; Ortigara et al., 2013; Trahan et al., 2014)
- Benefits of social support networks
- Focus on current, not prior, skills
- Recognize that environmental influences affect persons living with dementia

Activity/ Physical Activity

- Physical activity (PA) may improve cognitive thinking, physical fitness, and mood, but is not curative for dementia and does not slow its progression (Faulk et al., 2014; Kiepe et al., 2012; Kumar et al., 2014; Williams et al., 2010).
 - Not just "exercise"—walking, dancing (Holmerova et al., 2010; Vankova et al., 2014), gardening
- Many studies suggest that PA positively affects cognitive function in AD (Phillips et al., 2015) and PD (Ahlskog, 2011).
- Prospective studies note benefits of midlife physical activity on minimizing risk of Parkinson's disease (Ahlskog, 2014).
- A recent Cochrane Review (Forbes et al., 2015) shows:
 - Promising evidence that PA programs may improve ability to perform ADL
 - No clear evidence that PA benefits cognition, BPSD, or depression
- Activities can be simple, such as involving repetitive motions (like folding towels or putting coins in a holder) (Kales et al., 2014).
 - Care partner can help set up the activity.
 - Care partner can help an older adult participate.



Communication

- Allow PLwD sufficient time to respond to comment/question (Kales, et al., 2014).
- Use simple verbal commands, broken down into small steps.
- Use a calm, reassuring voice.
- Avoid harsh tones, negative words.
- Offer no more than 2 simple choices at a time.
- Identify self or others for person who is unable to remember names.
- Help person find appropriate words for self-expression.
- Lightly touch the person to provide reassurance, to calm, or to redirect if upset.

Cognitive Stimulation to Improve Cognitive Functioning

- In Cognitive Stimulation Therapy a range of activities aims to stimulate thinking, concentration, and memory in social settings (Spector et al., 2010; Woods et al., 2012)
 - Belief exists that lack of cognitive stimulation can lead to cognitive decline.
 - There is evidence of some benefit to persons with early- to middle-stage dementia.
 - Evidence suggests it is not beneficial or appropriate for persons with severe dementia.
- Reminiscence therapy (discussing past experiences) (Kales et al., 2015)

Sensory Stimulation

- Music therapy, white noise (with/without calming sounds) (Blackburn et al., 2014; Cohen-Mansfield et al., 2015; Li et al., 2015)
- Art/craft therapy (Pollanen et al., 2014; Safar, 2014)
- Bright light therapy (Figueiro et al., 2014; Forbes et al., 2014; Li et al., 2015; van Maanen et al., 2015)



Environmental Changes

- Environmental modifications (Trahan et al., 2014)
 - Remove clutter (Kales et al., 2014).
 - Use labels, visual cues (signs, arrows pointing to bathroom).
 - Change “objects and property” (Trahan et al., 2014).
 - Change “space demands.”
 - Change “social demands.”
 - Change “sequence and timing.”

Task Simplification

- Break tasks into simple steps (Kales et al., 2014).
- Use cues or prompts at each stage.
 - Verbal
 - Tactile
- Create structured daily routines.

Miscellaneous Nonpharmacologic Interventions

- Many other nonpharmacologic interventions that have been or are currently being investigated (Kales et al., 2014)
- Animal-assisted therapies (Cohen-Mansfield et al., 2015; Nordgren et al., 2014)
- Complementary and alternative therapies
 - Generally benign and of some limited benefit:
 - Massage, reflexology, chiropractic (Cohen-Mansfield et al., 2015)
 - Herbal supplements or dietary supplements: not always benign; be cautious.





Outline 6 - Identifying transitions to middle-stage dementia



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Creating Well Being

Zone thinking: Well being as the primary goal

Addressing the UN-met need

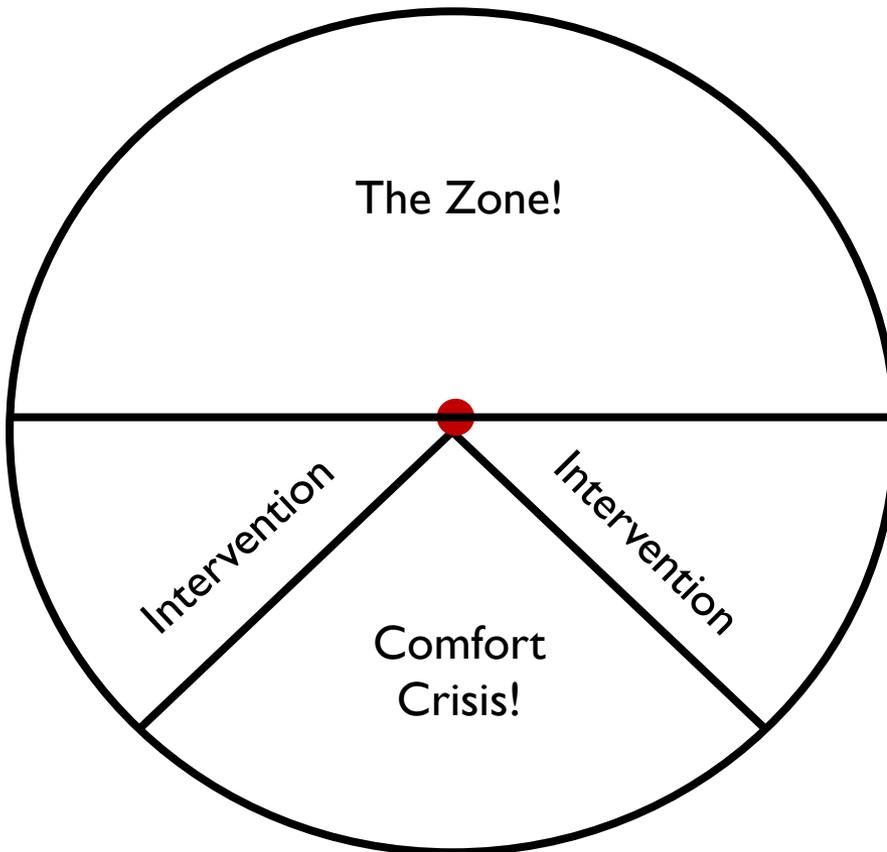
All behaviors are communication!

Team approach: Whatever it takes!

“Alternative approaches” are drugs. They are the last resort. Everything else is the primary way of being

Creating a Therapeutic Environment

Finding & Holding “The “Zone”



The Zone

- Comfort
- Safety/Security
- Well being
- Therapeutic Environment

CRYING
HOARDING
SMILING
MUMBLING
HUGGING
WANDERING
HITTING
SCRATCHING
BABBLING
FIDGETING
BITING
FROWNING
LAUGHING

All Behavior
Communicates

Care Partners Managing Memory Impairments and Executive Dysfunction

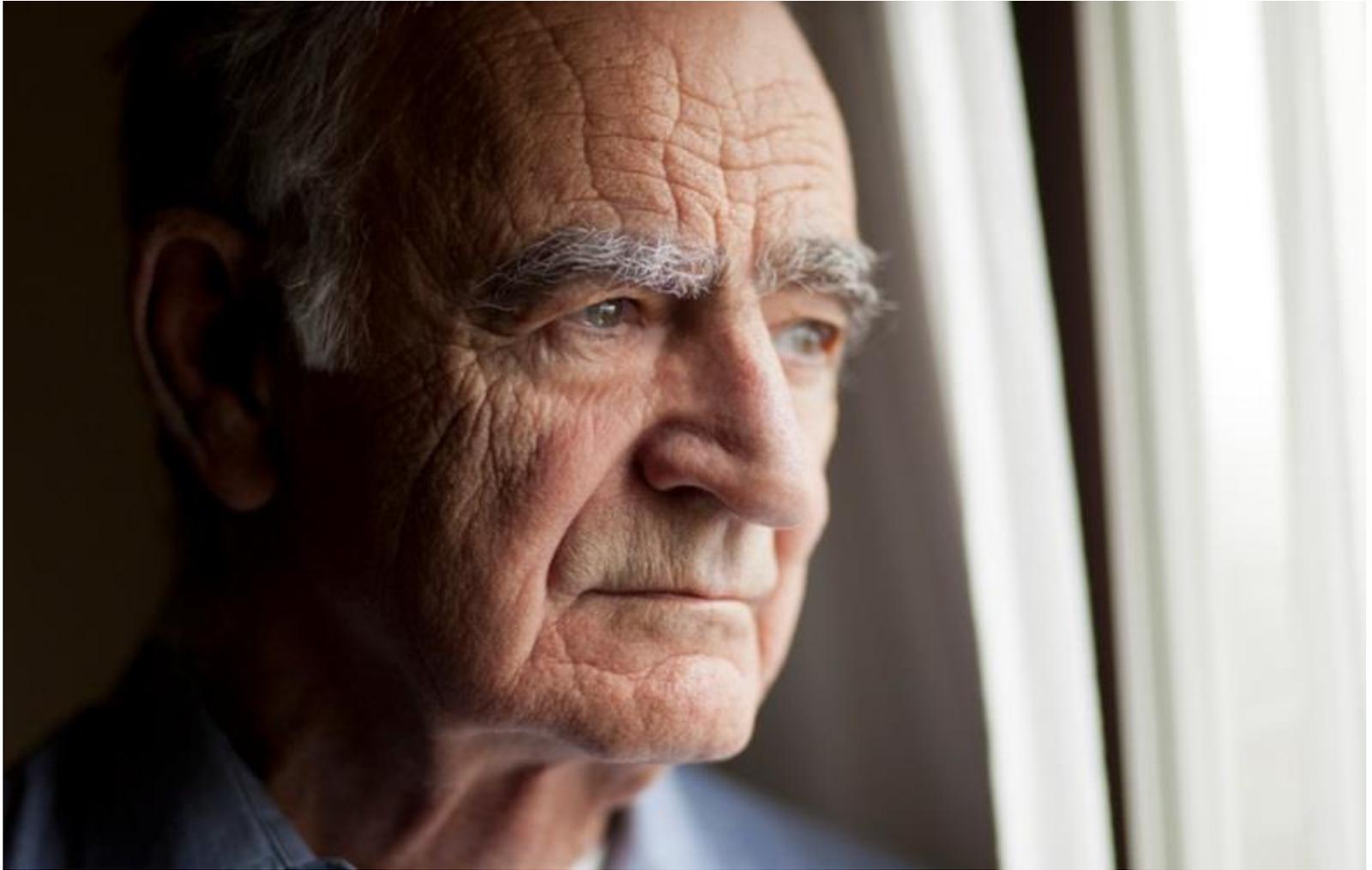
- Provide cues or prompts (Kales et al., 2014).
- Address repetitive questioning (Kales et al., 2014):
 - Respond with calm reassuring voice.
 - Use calming touch for reassurance.
 - Structure with daily routines.
 - Use distraction and meaningful activities.
 - Inform patient of events only as they occur.
- Address difficulties with IADL.

Care Partners Managing Memory Impairments and Executive Dysfunction

- Philosophy of care focused on well being – finding and holding the Comfort Zone
- Being fluent in Alzheimer's
- Drug free/minimal
- Personalized interventions
- Reduced Noise
- Transitioning
- Redefined “activity”
- A process to enhance sleeping & waking
- Restructured bathing

Mood Disturbances: Addressing Apathy

- Apathy is a common behavioral disturbance in all types of dementia, across all stages of dementia (Desai et al., 2012):
 - Apathy is commonly reported by family members and worsens over time (Kales et al., 2015).
 - Prevalence increases with increasing cognitive impairment.
 - Prevalence differs across different dementias (Brodaty et al., 2012; Desai et al., 2012; Kales et al., 2015).
 - It contributes to poor quality of life for PLwD and care partners.
- It is distinct from depression and does not necessarily coexist with other mood disturbances.



Mood Disturbances: Addressing Apathy (continued)

- Nonpharmacological management may reduce apathy (Brodaty et al., 2012; Kales et al., 2014).
 - Engaging the person living with dementia
 - Activity
 - Sensory stimulation
 - Environmental changes

Mood Disorders: Depression

- Depression is another common mood disorder in dementia (Desai et al., 2012; Kales et al., 2015; Kitching, 2015).
- Prevalence of clinically significant depression decreases with increasing cognitive impairment.
- Depression often coexists with anxiety symptoms (Desai et al., 2012).
- Relationship between depression and dementia is complex and not well understood (Bennett et al., 2014).
 - Evidence supports early life depression as risk factor for later life dementia (Bennett et al., 2014).
 - Later life depression is considered as a prodrome to dementia (Bennett et al., 2014).
 - Both show similar neurobiological changes (Kales et al., 2015).

Treating Depression in Dementia

- Depression has similar manifestations in persons with or without dementia (Kitching, 2015):
 - Low mood, irritability, anger; low energy, low appetite
 - Major depressive episodes more common in older persons with than without dementia
- It may be challenging to make differential diagnosis between depression and dementia because they can have some similar symptoms (Kitching, 2015).
- Management of depression in dementia can be similar to that of depression in the person without dementia (Kitching, 2015):
 - Nonpharmacologic strategies
 - Cognitive behavioral therapies (only in early-stage dementia)
 - Pharmacotherapy may be necessary (often with SSRIs)
 - Electroconvulsive therapy (ECT)

Medications for Cognitive Impairment in Early-stage Alzheimer's Disease

- Overall, benefits of symptomatic treatments are modest at best.
- Cholinesterase inhibitors are indicated for mild-to-moderate AD and may take up to 6 weeks before any apparent improvement (NIA, 2018b; Uriri-Glover et al., 2012).
 - Rivastigmine
 - Galantamine
 - Donepezil (may also be used for moderate-to-severe AD)
- Memantine: *N*-methyl-d-aspartate (NMDA) noncompetitive glutamate receptor antagonist is for moderate-to-severe AD (PubMed Health, n.d.).
- Combination of donepezil + memantine for persons with moderate-to-severe AD (Howard et al., 2012; Matsuzono et al., 2015).

Medication



WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

See full prescribing information for complete boxed warning.

- Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.
- NUPLAZID is not approved for the treatment of patients with dementia-related psychosis unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis.

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Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. RISPERDAL[®] is not approved for use in patients with dementia-related psychosis. (5.1)

- Black box warning
- Antipsychotic medications are ineffective and dangerous in this population
- There is no chemical rationale for their use to “treat symptoms of dementia”
- The Dopamine effect

Studies Show Low Effectiveness and High Danger

- **Antipsychotic effect takes 3-7 days to start working**
 - Very sedating medication so acute effect is most likely due to ***sedating effect not the antipsychotic effect***
- **Associated with adverse outcomes - increases risk for nursing facility residents of:**
 - Death (heart failure or pneumonia)
 - Hospitalization
 - Falls & fractures
 - Venothrombotic events (stroke)

Source: David Gifford, MD, AHCA, 2013

Providing Support to the Care Partner

- Help the care partner recognize when the person living with dementia has an unmet need (NIA, 2017c).
 - What is the relationship of the PLwD to the care partner?
- Zero in on troubling behaviors of the PLwD.
 - What is the behavior that concerns the care partner and what is it related to?
 - Does the behavior need to change or can the care partner live with it?
 - If it needs to change, what can be done?
- Utilize care partner strengths to see how many potential solutions can be found.
- Help the care partner recognize the importance of self-care.

Providing Support to Care Partners of Adults with Intellectual Disability

- Many PLwD who have an intellectual disability continue to live with a family member or an unrelated care partner. With progression from early dementia this may pose new care challenges for the care partners (Heller et al., 2018)
- Behavior will deteriorate and language skills lost
- Person may remain ambulatory for a prolonged time, but eventually become non-ambulatory
- Physical needs will become more prominent
- Care at home in early stages can enable continuity due to familiar setting and people that are known. Family may need supports for continued home care (respite, home modifications, aides to help primary care partner, financial assistance).
- With progression to latter stages, help with planning for advanced dementia and end of life care, palliative care, and hospice.



Case Study

Joellen, once an excellent cook, is beginning to experience difficulty in the kitchen. Her husband and primary caregiver is taking over many of the duties in the kitchen. His main challenge is how to keep his wife safely engaged in a task she has previously enjoyed doing and in which she was once quite accomplished. The problem is that she is at risk of causing potentially dangerous situations, such as putting a metal bowl in the microwave or putting a dish towel on the burner, or leaving the stove on.

Her husband solved this problem by arranging for them to cook meals together with him providing more supervision, asking Joellen to contribute by taking specific steps such as washing fruit and vegetables or assembling a salad, or having her assist with mealtime tasks outside of the kitchen such as setting the table.

Addressing Care Partner Issues

- Care partner roles depend on stage and type of dementia and where the PLwD resides (home or institutional setting) (Huang et al., 2015).
 - Early-stage dementia: Care partners provide assistance with transportation and housekeeping (Huang et al., 2015).
 - Middle-stage dementia: Care partners continue to aid and assist with mobility, ADL, and protection/safety (Huang et al., 2015).
 - Late-stage dementia: Care partners provide personal care of the PLwD and decision-making (Huang et al., 2015).
- Caring for PLwD, though rewarding and gratifying, can be stressful and difficult; caregiving responsibilities are increasingly time-consuming (Lazaroff et al., 2013).
 - Care partner requires support, education, guidance in providing appropriate care for PLwD as well as self.
 - Interprofessional team can provide education, identify support services to ensure care partner's needs are recognized and addressed (Lazaroff et al., 2013).



Outline 7- Addressing common manifestations and care partner issues of early-stage dementia



- Introduction
- Manifestations of early-stage dementia:
 - Overview
 - Alzheimer's disease (AD)
 - Vascular dementia (VaD) (and vascular cognitive impairment [VCI])
 - Lewy body dementia (LBD)
 - Frontotemporal degeneration (FTD)
- General strategies to address manifestations of dementia
- Identifying transitions to middle-stage dementia
- Addressing common manifestations and care partner issues of early-stage dementia

Symptoms Suggestive of Middle-Stage Dementia

- There are no clear biomarkers identifying stages for any cause of dementia (Archer et al., 2011).
- Increasing neurologic damage interferes with the (Archer et al., 2011):
 - Ability to express thoughts.
 - Ability to perform routine tasks.
 - Ability to perform ADL.
- There are more obvious problems with memory, confusion, behavioral and psychological symptoms of dementia (BPSD), and ADL (Ortigara et al., 2013).



Summary and Conclusions

- The older adult with early-stage dementia demonstrates noticeable impairments in memory and cognition along with some functional deterioration.
 - Generally able to remain at home and independent, with some assistance
- Behavioral and psychological symptoms of dementia (BPSD)—particularly sleep disorders and mood changes, and less frequently psychotic symptoms and agitation—often have the greatest effect on the older adult and care partner.
- An interprofessional team approach provides education, care, and support to the older adult and the care partner.

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Evaluation Link

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