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2024

NAVIGATING DEMENTIA

Assessment Tools Workshop: Tools & Referrals for Non-Clinicians

RESOURCE BOOK

FOR AGING SERVICES PROFESSIONALS & CAREGIVERS

Funded by a generous grant
from the Maryland Department of Aging

Maryland
DEPARTMENT OF AGING

UNIVERSITY of MARYLAND GRADUATE SCHOOL
Geriatrics and Gerontology Education and Research

WEBINAR & IN-PERSON* SESSIONS

MARCH 1 1-3 PM
CHANGES IN MEMORY

MARCH 8 1-3 PM
THE DEMENTIAS

***MARCH 22 9-4 PM**
COMMUNICATION

APRIL 19 1-3 PM
INTERVENTIONS

APRIL 24 8:30-2:30 PM
SERVICES & SUPPORTS

***MAY 10 9-4 PM**
ASSESSMENT & REFERRALS

MAY 24 1-3 PM
MARYLAND RESOURCES

*The Meeting House, Columbia, MD

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Spring 2024 "Navigating Dementia" Education Series

Description: The Geriatrics & Gerontology Education and Research (GGEAR) program at University of Maryland, Baltimore, with generous support from the Maryland Department of Aging, is pleased to announce our new professional development and community education program entitled "**Navigating Dementia.**" Alzheimer's disease and related dementias (ADRD) represent a growing public health crisis. Across Maryland, there are an estimated 110,000 individuals aged 65 and older living with ADRD and nearly 240,000 unpaid family members providing care to these individuals. Recognizing the unique needs of these groups, GGEAR is hosting a series of five webinars and two in-person conferences that are FREE and open to the public.

The "Navigating Dementia" educational series is intended for Aging Services professionals, caregivers of persons living with ADRD, and anyone with an interest in matters concerning older adults. The series will provide valuable knowledge, resources, and support on topics related to aging, cognitive health, dementia care, and caregiving in Maryland.

Overall objectives:

1. Advance personal understanding of dementia.
2. Formulate realistic expectations based on the effects of dementia on persons living with ADRD and their caregivers.
3. Demonstrate confidence in interactions that reflect evidence-based, unbiased, culturally sensitive approaches to care; and
4. Create meaningful living opportunities for adults living with Alzheimer's disease or related dementia in Maryland.

In-Person Conference: Friday, May 10, 2024 (9:00 am-4:30 pm; check-in begins at 8:30 am)

Title: Assessment Tools Workshop: Tools & Referrals for Non-Clinicians

Description: An immersive, interactive conference with break-out workshop designed to equip non-clinical professionals and caregivers with essential skills and knowledge for effective Alzheimer's assessment and care. Topics include non-clinical assessments for dementia; polypharmacy; and depression, effective referrals and expectations during clinical evaluation, and caregiver support.

Objectives: By the end of this conference, attendees will be able to:

- Understand the prevalence of ADRD in Maryland and its disproportionate impact in communities of color;
- Recognize the importance of early diagnosis of Alzheimer's Disease and Related Disorders;
- Execute assessment strategies, with a focus on interrater reliability, and recognize when referral is warranted; and
- Apply a person-centered approach supportive of the person living with ADRD and his/her care partners.

THE SCHEDULE FOR TODAY

Time	Schedule		Location	Theme	Speaker
8:30 AM	**Doors Open**	Continental Breakfast Available			
9:00 AM	**Conference Begins**			Housekeeping Remarks	Tre'Jenae Mack
9:05-9:50 AM	**Keynote Lecture**			Prevalence, Impact & Early Warning Signs of Dementia	Ilene Rosenthal, MSW
9:50-10:00 AM	**BREAK**				
10:00-10:45AM	**Session 1**	Break-out A		Eight-Item Informant Interview to Differentiate Aging and Dementia (AD8) Screening Tool	Rachel McPherson, PhD
		Break-out B		Polypharmacy in Older Adults	Nancy Rodriguez-Weller, RPh.,FASCP
		Break-out C		Assessing Client Care Ecosystems with Atlas Care Maps	Kate Gordon, MSW
		Break-out D		Using the Mini-Cog to Assess Cognition	Laura Gillen, MS
10:45-10:55 AM	**BREAK**				
10:55AM-11:40 AM	**Session 2**	Break-outs A-D			
11:40-12:15 PM	**Lunch & Visit the Exhibitors**				
12:15-1:15 PM	**Keynote Lecture**			Helping Care Partners of Persons Living with Dementia	Valerie Cotter, DrNP
1:15-1:25	**BREAK**				
1:25-2:10 PM	**Session 3**	Break-outs A-D			
2:10-2:20 PM	**BREAK**				
2:20-3:05PM	**Session 4**	Break-outs A-D			
3:05-3:15 PM	**BREAK**				
3:15-4:15 PM	**Keynote Lecture**			Screening for Depression & Tips and Steps for Early Screening and Care Pathways in Dementia and Depression	Cynthia Fields, MD
4:15-4:30 PM	**Wrap-Up & Evaluations**				

KEYNOTE SPEAKERS

Ilene Rosenthal, MSW
Alzheimer's Association, Greater Maryland Chapter

As Program Director for the Alzheimer's Association, Greater Maryland Chapter, Ms. Rosenthal provides leadership and strategic direction for the implementation, growth, and quality of Association programs and services. Prior to joining the Alzheimer's Association, she served as the Deputy Secretary of the Maryland Department of Aging where she led the administration and management of the Department's programs and operations and contributed to the development of public policy in the areas of aging and long-term care reform. She holds B.A. degrees in Social Work and Psychology from the University of Maryland Baltimore County and an M.S.W. from the University of Maryland School of Social Work.

Valerie T. Cotter, DrNP, AGPCNP-BC, FAANP, FNAP, FAAN

Valerie Cotter is Associate Professor, Johns Hopkins University with a joint appointment in the School of Nursing and School of Medicine, Department of Psychiatry and Behavioral Sciences. She received academic degrees from Drexel University (DrNP), University of Pennsylvania (MSN), and University of Massachusetts (BSN). Dr. Cotter leads innovations in nursing education, research, and specialty care of persons with dementia and their caregivers with four decades of sustained service. She has extensive teaching experience in academic nursing and interprofessional programs, as Director of the University of Pennsylvania's Gerontological Nurse Practitioner Program, Educational Director of the Alzheimer's Disease and Research Center and core faculty of Cognitive Impairment Programs at the Delaware Valley Mid-Atlantic Geriatric Education Center. She is a Fellow of the American Association of Nurse Practitioners, American Academy of Nursing, and the National Academies of Practice, a Cambia Health Foundation Sojourns Scholar, and co-editor and author of two books, 50 publications and numerous national and international presentations.

Dr. Cynthia Fields, Geriatric Neuropsychiatrist
Johns Hopkins School of Medicine

Dr. Fields is an assistant professor and clinical co-director of MIND at Home (Maximizing Independence at Home), a home-based care delivery model for dementia that optimizes care for patients living with dementia and that provides much needed support to family caregivers by delivering cost-effective interventions and care strategies. She is certified by the American Board of Psychiatry and Neurology and as a Geriatric Psychiatrist. She received her Medical Degree in 2004 and completed her Residency in Psychiatry from 2004-2008 at Tulane University School of Medicine in New Orleans, LA. Dr. Fields completed her Fellowship in Geriatric Psychiatry and Neuropsychiatry from 2008 to 2010 with the Johns Hopkins University School of Medicine, in Baltimore, MD. Prior to joining the faculty at Johns Hopkins, Dr. Fields was with the Copper Ridge Assessment Clinic and the Johns Hopkins Neuropsychiatry Institute.

BREAK-OUT SESSION FACILITATORS

Kate Gordon, **MSW**
Splaine Consulting

Kate Gordon has provided consultation on health and aging policy strategy at the global, national, state, and local level for over 20 years. She was a health policy analyst for the Administration for Community Living, providing technical assistance to state agencies and local social/health services agencies, through the National Alzheimer's and Dementia Resource Center. In this role, she helped community-based aging programs develop intake, assessment, and program evaluation tools. Ms. Gordon is a consultant for NIH-funded R01 research programs focused on dementia caregiver interventions and persons who live alone with dementia and teaches health policy strategy at UMBC, UMass Boston, and the University of California San Francisco.

Ms. Gordon also led the National Alzheimer's Association's grassroots efforts to accomplish state and federal policy priorities, with a focus on restructuring Medicaid long-term care, comprehensive state Alzheimer's plans, and quality residential care for persons with dementia in assisted living facilities and nursing homes. In 2023, Kate enrolled as a full-time PhD student at the Johns Hopkins School of Public Health. She is also a primary caregiver for a 97-year-old Maryland resident living with dementia.

Nancy Rodriguez-Weller, RPh., FASCP

Owner and President, Consultant Pharmacist – Geriatric Pharmacy Consulting Services. Retired Assistant Professor, University of Maryland Eastern Shore, Pharmacy Practice, School of Pharmacy and Health Profession, Graduated from Howard University, in 1981. Past clinical pharmacist at Children's Medical Center and Peninsula Regional Med. Center in Salisbury, Maryland, Past Director of Pharmacy in long-term care infusion; Member of Virginia I. Jones Alzheimer's Disease and Related Disorders Council under the direction of Gov. of the State of Maryland. Awarded Consultant Pharmacist of the Year by the ASCP Maryland Chapter, and the "Top 100 Woman" award in Maryland for volunteerism with older adults in global health in Nicaragua, Honduras, Guatemala, Puerto Rico and Peru. Her primary focus in practice is on geriatric pharmacotherapy especially as it relates to geriatric medication management in long-term care settings.

Rachel McPherson, PhD

Dr. McPherson is a Postdoctoral Fellow at the University of Maryland School of Nursing. She received her Doctor of Philosophy in Gerontology from the University of Maryland, Baltimore. Her work is focused on evaluating and improving the quality of staff-resident care interactions among long-term care residents with dementia.

Laura Gillen, MS Education, MS Gerontology
Certified Brain Longevity Specialist

Laura is an applied gerontologist, educator, and care partner. Her goal is to optimize aging outcomes through education, advocacy, and translational research. She believes that meaningful living as well as finding joy in everyday life are key to what matters most, and these can be achieved for all of us.

Her roles in the community focus on helping others to navigate a dementia or life course journey, educating on evidence-based best practices and strategies, and advocating for support and positive change.

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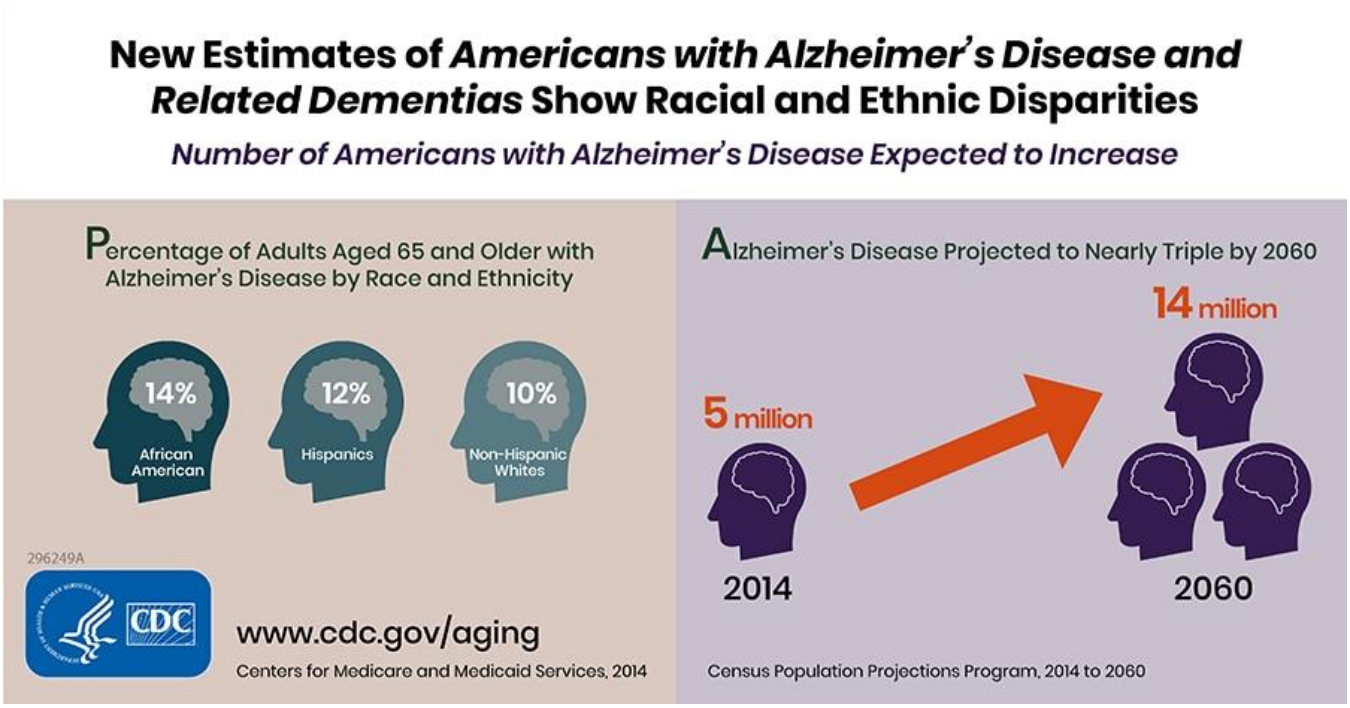
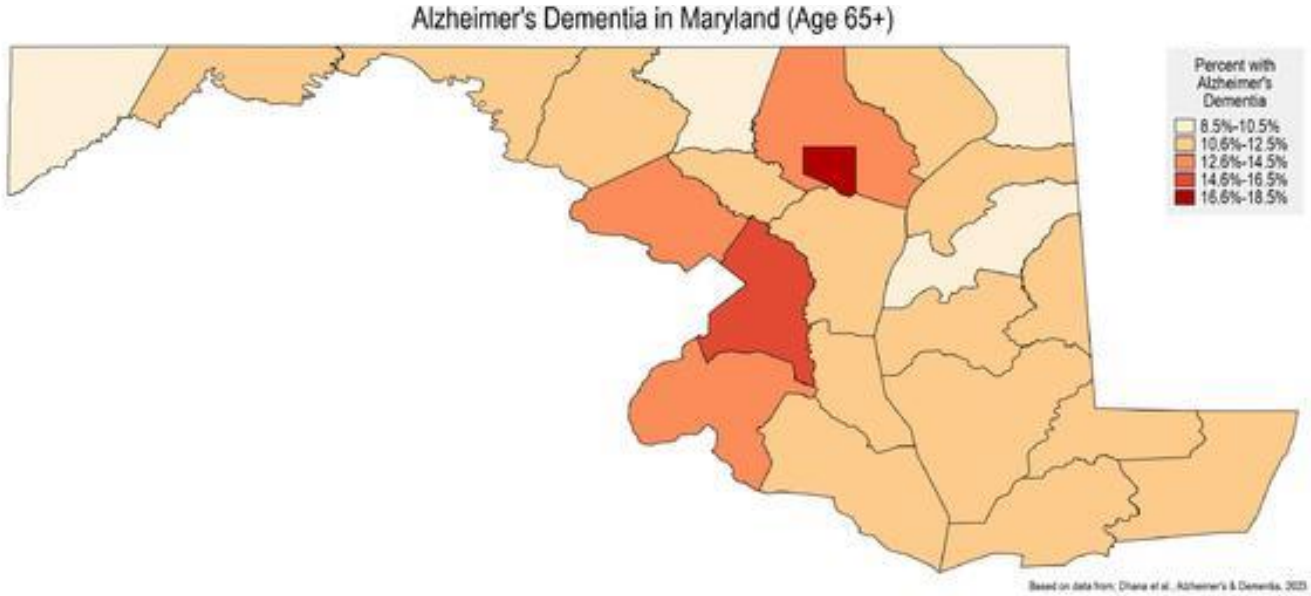


PREVALENCE OF DEMENTIA IN MARYLAND

"Baltimore City is tied for the highest prevalence rate for dementia (16.6%) in the nation for counties with a population of 10,000 or more people 65 or older. Prince George's County follows close behind by less than a percentage point. The prevalence rate for Baltimore County is 13.1%."
https://www.cbsnews.com/baltimore/news/baltimore-city-highest-alzheimers-disease-rate-prevalence/



LET'S TALK ABOUT ASSESSMENT TOOLS FOR ADRD

It is time to debunk common myths or misconceptions about the assessment process. Get ready to become an expert!

MYTH: All assessment tools for Alzheimer's disease are equally accurate.	UNTRUE! While there are many assessment tools available, they vary in accuracy and suitability for different stages and types of dementia. Some tools are more comprehensive and validated than others.
MYTH: Assessment tools can definitively diagnose Alzheimer's disease.	IT'S JUST A FIRST STEP - Assessment tools can provide valuable information, but a definitive diagnosis of Alzheimer's disease usually requires a combination of medical history, physical examination, cognitive testing, and sometimes brain imaging.
MYTH: Only doctors can administer Alzheimer's assessment tools.	TRAINING MATTERS While doctors often administer assessment tools, other healthcare professionals such as neuropsychologists, nurses, and occupational therapists may also be trained to administer and interpret these tests.
MYTH: Assessment tools are only useful for diagnosing Alzheimer's disease.	AND MORE...Assessment tools are also valuable for tracking disease progression, monitoring treatment effectiveness, and identifying other types of cognitive impairment that may require intervention.
MYTH: Assessment tools are one-size-fits-all.	THERE'S A BETTER APPROACH- Different assessment tools may be more appropriate depending on factors such as the individual's age, education level, cultural background, and language proficiency. Tailoring the assessment to the individual's needs and circumstances can improve accuracy and reliability.

What Causes Memory Loss? Assessing Symptoms and Seeking Help

https://www.alz.org/alzheimers-dementia/memory-loss-concerns

Various conditions can cause short-term or long-term memory loss and affect thinking or behavior.
It can be difficult to know what to do if you've noticed changes in yourself or a family member or friend — particularly changes related to memory loss, thinking or behavior. It may just be normal forgetfulness, or it may be something more serious. It's natural to feel uncertain about voicing your worries because that can make them seem more "real." However, these are significant health concerns, and it's important to take action to figure out what's going on.

Assess the situation:

- **What changes in memory, thinking or behavior do you notice?**
  What have you noticed that's out of the ordinary and causing concern?
- **What else is going on?**
  Various conditions can cause short-term or long-term memory loss and affect thinking or behavior. Are there any health or lifestyle issues that could be a factor? These may include family stressors or medical problems like diabetes or depression. It's also possible that poor hearing or vision are contributing to these changes.
- **Has anyone else noticed changes?**
  Has a family member or friend expressed concerns? What did he or she notice?
- **Are any of these changes a sign or symptom of Alzheimer's or another dementia?**
  View the 10 early signs and symptoms of Alzheimer's to check if they're on the list.

Start a conversation:

- **Who should participate in the conversation to discuss concerns?**
  If you've noticed changes in yourself, confide in a person you trust. If you've noticed changes in someone else, the person who has the conversation could be you, a trusted family member or friend or a combination of these individuals.
- **What is the best time and place to have this conversation?**
  Have the conversation as soon as possible. Choose a time and location that will be comfortable for everyone involved.
- **How will you approach the conversation?**
  Try the following if you've noticed changes in yourself:
  - I've noticed [blank] in myself, and I'm concerned. Have you noticed anything about me that worries you?
- **Try the following if you've noticed changes in someone else:**
  - I've noticed [blank] in you, and I'm concerned. Have you noticed it? Are you worried?
  - How have you been feeling lately? You haven't seemed like yourself.
  - I noticed you [specific example], and it worried me. Has anything else like that happened?

Evaluating memory at home or in a non-clinical setting:

There are several tools and strategies that families and non-clinicians can use to evaluate memory concerns. These can be helpful for monitoring memory concerns at home, but they are not a substitute for professional evaluation and diagnosis by a healthcare provider. If memory concerns persist or worsen, it's essential to seek guidance from a medical professional for proper assessment and management.

Memory Journals: Encourage the individual experiencing memory concerns to keep a journal or diary. He or she can write down important events, tasks, or information they want to remember. Reviewing these entries over time can help identify patterns of forgetfulness or changes in memory.

Medication Management Tools: Use pill organizers or medication reminder apps to help manage medications and track adherence. Forgetting to take medications as prescribed can be an early sign of memory issues.

Digital Apps and Tools: There are many smartphone apps designed to assess and track memory function. Some of these apps offer memory games, cognitive exercises, and memory tests that can be used to monitor changes over time.

Observation: Family members and others who have regular contact with the person experiencing forgetfulness can provide valuable insights into changes in memory and cognition. Encourage open communication and discuss any concerns or observations with everyone involved.

Memory Tests: While not as comprehensive as professional assessments, there are online memory tests and quizzes that individuals can take to get a rough idea of memory function. These tests should be used as a screening tool rather than a diagnostic tool.

Some important notes about interrater reliability in non-clinical assessments:

Consistency in Observations: High interrater reliability means that regardless of who conducts the assessment, similar observations and judgments about the individual's cognitive function can be made. However, family members might interpret the same behaviors or signs of cognitive impairment differently. Consistent observations among different assessors provide stronger evidence that the assessment accurately reflects the individual's cognitive abilities and functional status. Reliable assessments are essential for sharing information with healthcare providers so that they can develop appropriate treatment plans and interventions for individuals.

To ensure interrater reliability in a non-clinical assessment for dementia, it's important to:

1. Provide clear assessment guidelines and criteria for the assessors to follow.
2. Use standardized assessment tools appropriate for a non-clinician, such as those provided below, and be sure to ask all questions as written. Do not skip a question or reword it. Everyone should ask the same questions in the same way.
3. Encourage open communication among assessors to discuss any discrepancies in observations and reach consensus on the assessment findings.

TRY THIS

Dementia Series

Best Practices in Nursing Care to Older Adults

The AD8: The Washington University Dementia Screening Test

("Eight-item Interview to Differentiate Aging and Dementia")

By: James E. Galvin, MD, MPH, University of Miami Miller School of Medicine

WHY: Alzheimer's disease (AD) and other dementias are under-recognized and under-diagnosed in the community (Galvin et al., 2005). Primary care practitioners are the most likely provider to detect early symptoms of AD and other dementias in older adults. In primary care settings, providers can expect 11% of people 65 and older and 32% of those 85 and older to have AD, with the incidence expected to rise due to the increasing number of people aged 65 and older (Alzheimer's Association, 2022). Screening to identify older adults early in the disease process is important in order to offer treatment and future planning for the patient and their family caregivers. This *Try This:*® document describes The AD8: The Washington University Dementia Screening Test, also known as "*Eight-item Interview to Differentiate Aging and Dementia*" (AD8), a short and simple to use instrument that an informant or older adult can complete prior to seeing the primary care provider or other health care practitioner (Galvin et al., 2005, 2006, 2007a, 2007b).

BEST TOOL: The AD8 was developed as a brief instrument to help discriminate between signs of normal aging and mild dementia. The AD8 contains 8 items that test for memory, orientation, judgment, and function. Cut points are: normal cognition 0-1; impairment in cognition 2 or greater. In contrast to instruments such as the Mini Cog and the Folstein Mini Mental State Examination (MMSE), the AD8 assesses intra-individual change across a variety of cognitive domains compared to previous levels of function and is sensitive to early signs of dementia regardless of etiology. The AD8 was originally validated as an informant-based interview, completed by a spouse, adult child, friend who knew the older adult well. The AD8 has also been validated as a direct questionnaire for the person with potential dementia who can often rate change in performance into the later stages of dementia (Galvin et al., 2007b). The AD8 is short, simple, and quick to administer (~3 minutes) and culturally sensitive, thus making it an ideal tool for use in primary care practice during the annual wellness visit and research. Additionally, it has been validated for use in emergency departments and other settings (Carpenter et al., 2011) and has been translated into a number of languages. Further information regarding the AD8 can be found at https://knightadrc.wustl.edu/professionals-clinicians/ad8-instrument/

TARGET POPULATION: Use with Medicare beneficiaries during their Medicare Annual Wellness visits as the AD8 meets requirements for the cognitive assessment component. Given that 81% of people with Alzheimer's disease are 75 years or older (Alzheimer's Association, 2016), in primary care consider screening this population at any visit and update the AD8 record annually. Adults younger than 75 who are experiencing changes in cognition or whose family or friends have noticed a change should also complete an AD8.

VALIDITY AND RELIABILITY: In community residing older adults, the AD8 reliably differentiates non-demented from demented community residing individuals and is sensitive to early signs of cognitive change as reported by an informant. Concurrent validity is strong, with the AD8 correlating highly (r = 0.75) with the Clinical Dementia Rating (CDR), a gold standard global rating system and a formal neuropsychological evaluation. Sensitivity of >84% and a specificity of >80% has been reported. It has strong interrater reliability and stability. It shows excellent discrimination between non-demented and cognitively impaired individuals (positive predictive value >85%; negative predictive value>70%. Area under the Curve: 0.908; 95% CI: 0.888-0.925). Combining the AD8 with a brief performance test such as the MoCA and Mini-Cog greatly enhances the ability to capture early cognitive change (Galvin et al., 2007a) (See *Try This:*® MoCA and *Try This:*® Mini Cog).

STRENGTHS AND LIMITATIONS: The strengths of the AD8 are that it is short, takes on average 3 minutes to complete, and requires no advanced training. Items test for intra-individual change in multiple domains. It may be completed by the older adult or by a reliable informant, either in-person or over the phone. It has been tested on a diverse sample of white and nonwhite community residing older adults. In contrast to other measures, the AD8 captures changes in cognition in high functioning individuals and thus lends itself to use in primary care practice. A potential drawback to the AD8 exists if the patient has no informant, although this may only limit the usefulness of the AD8 for ongoing monitoring.

FOLLOW-UP: Positive screen on the AD8 require further assessment including history, physical examination, standard cognitive assessment instruments, laboratory testing, and brain imaging to formally establish a dementia diagnosis.

The AD8: The Washington University Dementia Screening Test

("Eight-item Interview to Differentiate Aging and Dementia")

Administration

The questions are given to the respondent on a clipboard for self–administration or can be read aloud to the respondent either in person or over the phone. It is preferable to administer the AD8 to an informant, if available. If an informant is not available, the AD8 may be administered to the patient.

When administered to an informant, specifically ask the respondent to rate change in the patient.

When administered to the patient, specifically ask the patient to rate changes in his/her ability for each of the items, *without* attributing causality.

If read aloud to the respondent, it is important for the clinician to carefully read the phrase as worded and give emphasis to note changes due to cognitive problems (not physical problems).
There should be a one second delay between individual
items. No timeframe for change is required.

Scoring

The final score is a sum of the number items marked "Yes, A change".

Interpretation of Results

0-1: Normal cognition:
2 or greater: Impairment in cognition

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., computer, micro- wave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			

TOTAL AD8 SCORE	

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

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.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

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.

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.

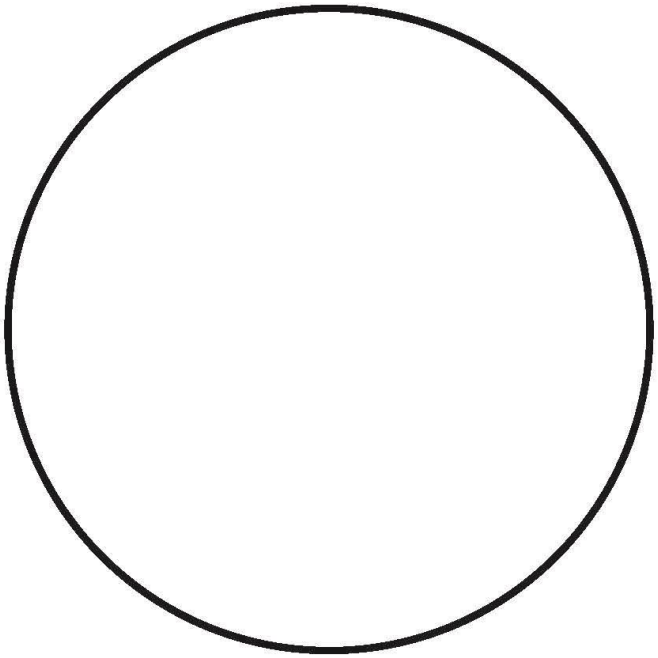
Word List Version: ____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	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.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <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 <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID: _____ Date: _____



References

1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population-based sample. J Am Geriatr Soc 2003;51:1451–1454.
2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.
3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.
4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.
5. McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.
6. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.
7. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2001; 16: 216-222.

There's More to Learn about Cognitive Assessments!

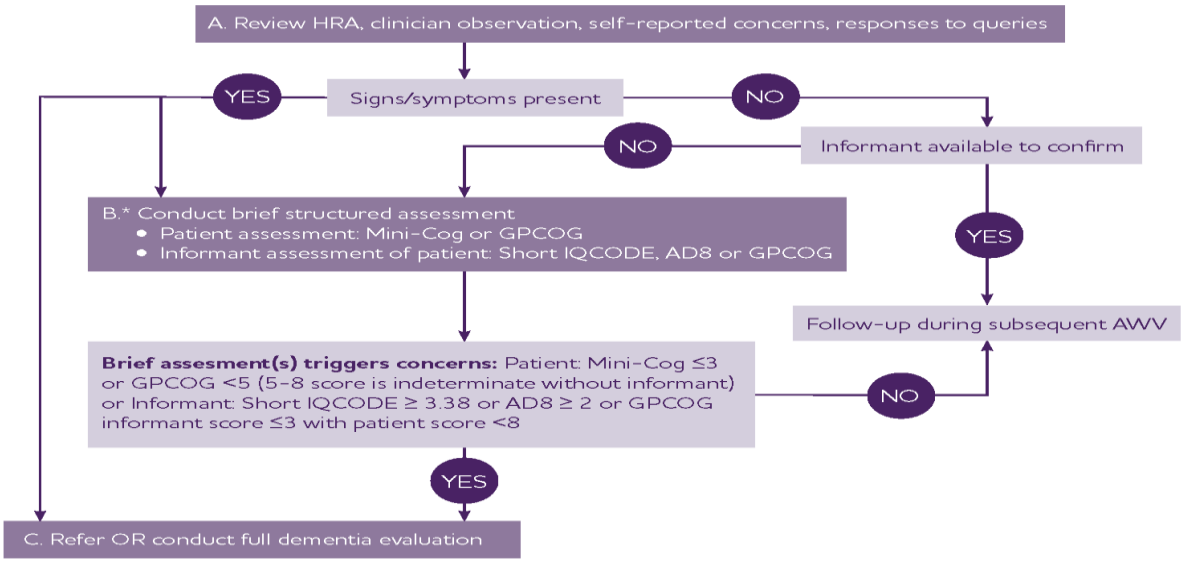
https://www.alz.org/professionals/health-systems-medical-professionals/cognitive-assessment

Who should be evaluated for cognitive impairment?

- Individuals with memory concerns or other cognitive complaints. Non-memory triggers include personality change, depression, deterioration of chronic disease without explanation, and falls or balance issues.
- Other people who have concerns about changes they've noticed in an individual, even if the person doesn't think there is a problem.
- Medicare beneficiaries, as part of the Annual Wellness Visit

Alzheimer's Association®

Medicare Annual Wellness Visit Algorithm for Assessment of Cognition



* No one tool is recognized as the best brief assessment to determine if a full dementia evaluation is needed. Some providers repeat patient assessment with an alternate tool (e.g., SLUMS, or MoCA) to confirm initial findings before referral or initiation of full dementia evaluation.

AD8 = Eight-Item Informant Interview to Differentiate Aging and Dementia; **AWV =** Annual Wellness Visit; **GPCOG =** General Practitioner Assessment of Cognition; **HRA =** Health Risk Assessment; **MoCA =** Montreal Cognitive Assessment; **SLUMS =** St. Louis University Mental Status Exam; **Short IQCODE =** Short Informant Questionnaire on Cognitive Decline in the Elderly

Cordell CB, Borson S, Boustani M, Chodosh J, Reuben D, Verghese J, et al. Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting. *Alzheimers Dement.* 2013;9(2):141–150. Available at https://alz-journals.onlinelibrary.wiley.com/journal/15525279

Benefits of early detection

- Ensuring people receive the most benefit from treatment options at the earliest point possible

- More time to plan for the future
- Lessened anxieties about the unknown
- Increased chances of participating in clinical studies, helping advance research
- An opportunity to participate in decisions about care, transportation, living options, financial and legal matters.
- Time to develop a relationship with doctors and care partners.
- Access to care and support services, making it easier for them and their family to manage the changes that come with the disease.

Indications for referral

Not all primary care physicians will want to conduct a full dementia evaluation. Possible indications for referral to a neurologist, neuropsychologist or geriatrician include:

- Inconclusive diagnosis
- Atypical presentation
- Behavioral/psychiatric symptoms
- Younger onset (< 65 years)
- Second opinion
- Patient/family preference
- Family dispute
- Caregiver support

Differential Diagnosis: Polypharmacy

What is Polypharmacy?

Polypharmacy is using multiple prescription drugs. According to a report from the U.S. Centers for Disease Control and Prevention, about a third of American adults in their 60s and 70s use five or more prescription drugs regularly.

Though the definition of polypharmacy may vary among doctors and groups, it is recognized that the more medicines a person takes, the higher the chance of overmedication, side effects, oversedation, and other problems.

Polypharmacy Symptoms

Symptoms of polypharmacy can include: Reduced alertness; **Confusion or cognitive problems**; Falls and accidents; Weakness and dizziness; Loss of appetite; GI problems such as diarrhea, constipation or incontinence; Skin rashes; Depression; Anxiety; Excitability

Risks of Polypharmacy in Older Adults

Polypharmacy affects older women and men differently than younger people. For instance, some drugs work differently in older people. A person over the age of 60 may have a different body composition than a person who is 35 and may process medications differently.

Also, when new drugs are tested on people before going on the market, test subjects may not include older adults, so these differences are not always readily identified by the manufacturers.

Managing Polypharmacy

The best polypharmacy prevention measure is regular checkups with a health care practitioner, including medication review. High-quality care means reviewing all the patient's medications at least once a year and after any fall, hospitalization or emergency department visit.

Managing polypharmacy involves understanding what matters most to the patient — whether it's managing a health condition or avoiding intolerable side effects. It's a highly individualized process that calls for careful listening and candid conversation.

https://www.cdc.gov/nchs/products/databriefs/db347.htm
Polypharmacy in Adults 60 and Older | Johns Hopkins Medicine

Differential Diagnosis: Depression

Primary Depression	Primary Dementia
noticeable onset of symptoms	slow, gradual onset of symptoms
rapid progression of symptoms	slow progression of symptoms
complains of cognitive problems (concentration, memory, decision making)	no complaints of cognitive problems
emphasizes cognitive complaints	tries to conceal or 'explain away' cognitive concerns
highlights personal failures	emphasizes personal accomplishments
makes little efforts at tasks	struggles with tasks
does not try to keep up	relies on notes and calendars to keep up
in distress	is unconcerned

Formal Evaluation of Memory and Thinking Problems: What to Expect

A clinical assessment for dementia is a thorough process often completed by teams of specialists designed to evaluate an individual's cognitive and functional abilities to determine whether dementia might be present and, if so, to help identify the specific type and stage of the disease. The evaluation may be divided into several visits, allowing time to gather information to accurately determine the cause of your concerns and rule out other possibilities. Here's what you can generally expect during a clinical assessment for dementia:

1. Medical History

General Health: The doctor will ask about the patient's overall health, past medical problems, and current symptoms.
Family History: Information on family health history, especially any family members with dementia or related conditions.
Medication Review: A review of all medications (prescription, over-the-counter, and supplements) the patient is taking, as some can affect cognitive abilities.

2. Cognitive Tests

Memory Assessment: These tests evaluate short-term and long-term memory.
Problem Solving and Reasoning: Tasks to assess the patient's ability to plan, organize, and follow through with tasks.
Language and Communication Skills: Tests to evaluate how well the patient uses and understands language.
Attention and Orientation: Questions to determine the patient's awareness of time, place, and identity.

3. Physical Examination

Neurological Exam: Checks for problems with movement, muscle control, balance, and other signs that could be related to brain disorders.
Sensory Evaluation: Tests to see if sensory issues might be affecting cognitive abilities.

4. Psychiatric Assessment

Mood and Behavior: Evaluations to determine if depression, anxiety, or other psychological factors might be contributing to cognitive symptoms.

5. Brain Imaging

CT or MRI: These scans are used to check for brain shrinkage, strokes, tumors, or other physical abnormalities that might cause symptoms of dementia.
PET Scans: Sometimes used to look at brain activity patterns and to help differentiate between types of dementia.

6. Laboratory Tests

Blood Tests: Can help rule out other conditions that might mimic dementia, such as thyroid dysfunction or vitamin deficiencies.
Other Tests: Depending on symptoms and medical history, additional tests might be ordered to explore other diagnostic possibilities.

7. Functional Assessment

Daily Living Skills: Assessments to determine how well the individual is managing daily activities such as dressing, eating, and managing finances.
Interviews with Family Members: Doctors often talk with family members to gather more information about the individual's symptoms and how they impact their life.

8. Follow-up and Planning

Diagnosis Discussion: The doctor will discuss the findings with the patient and family members, providing a diagnosis if one is determined.
Care Planning: Recommendations for managing symptoms, addressing care needs, and planning will be discussed, including the involvement of specialists if needed.

9. Referrals and Support

Referrals to Specialists: Referrals to other specialists might be suggested for further evaluation or treatment.
Support Services: Information about support groups, social services, and community resources that can help the patient and family cope with the diagnosis.

The clinical assessment process can be emotional and challenging for the patient and his/her family. It is important to go into it with support and to prepare questions and concerns to discuss with the specialists and follow-up with your healthcare provider to ensure comprehensive care and planning.

A Person-Centered Focus is the Core of Quality Care

https://www.alz.org/professionals/professional-providers/dementia_care_practice_recommendations

Person-centered focus: Dementia care should prioritize the individual's needs, preferences, and abilities. It involves recognizing the personhood of individuals with dementia and respecting their autonomy and dignity.

Assessment and care planning: Involves a thorough assessment of the person's cognitive, functional, and psychosocial status to develop a comprehensive care plan tailored to their specific needs. This plan should be regularly reviewed and adjusted as the condition progresses.

Medical management: Includes medical interventions such as pharmacological treatments for managing symptoms and addressing comorbid conditions. It also involves regular medical monitoring to track the progression of the disease and adjust treatment accordingly.

Information, education, and support: Providing information and education to individuals with dementia and their caregivers helps them better understand the condition, manage symptoms, and plan for the future. Support services such as counseling, support groups, and respite care can also be beneficial.

Dementia-related behaviors: Understanding and managing challenging behaviors associated with dementia, such as agitation, aggression, wandering, and sundowning, are crucial aspects of care. This may involve environmental modifications, behavioral interventions, and sometimes pharmacological treatments.

Activities of daily living: Helping individuals with dementia maintain independence in activities of daily living, such as bathing, dressing, eating, and toileting, is essential for their quality of life and overall well-being.

Workforce: Ensuring that healthcare professionals involved in dementia care, including physicians, nurses, social workers, and caregivers, have the necessary knowledge, skills, and resources to provide high-quality care.

Supportive and therapeutic environment: Creating a supportive and dementia-friendly environment can enhance the well-being of individuals with dementia. This includes modifications to the physical environment, such as reducing noise and clutter, as well as providing meaningful activities and social engagement.

Transition and coordination of services: Coordinating care across different healthcare settings and ensuring smooth transitions between home, hospital, and long-term care facilities is essential for continuity of care and optimal outcomes.
Detection and diagnosis: Early detection and accurate diagnosis of dementia are crucial for timely intervention and support. This involves recognizing early signs and symptoms, conducting thorough assessments, and ruling out other possible causes of cognitive impairment.

Reach out for help:

- **Turn to the Alzheimer's Association for information and support.**
    - Call the 24/7 Helpline at 800.272.3900 to speak with a master's-level clinician about concerns and next steps.
    - Explore the Community Resource Finder to find local resources such as a healthcare professional or your closest Alzheimer's Association chapter.
    - Visit the Training and Education Center to take an online course anytime and learn more about a variety of topics related to Alzheimer's and dementia.

Atlas Care Mapping: Understanding Who You Care For and Who Cares For You

Atlas Care Maps provides a structured methodology to map out and analyze the various elements of care and support that individuals receive within their healthcare journey. Here's how the process generally works:

Identifying Stakeholders: Begin by identifying all the stakeholders involved in the client's care ecosystem. This may include healthcare providers, caregivers, family members, community organizations, and other support networks.

Mapping the Care Journey: Create a visual representation of the care journey using an Atlas Care Map. This map should include key touchpoints such as diagnosis, treatment, follow-up care, and ongoing support. Each touchpoint should be linked to the stakeholders involved and the services provided.

Analyzing Interactions: Examine the interactions between stakeholders and services at each touchpoint on the Atlas Care Map. Look for strengths, weaknesses, gaps, and opportunities for improvement in the care ecosystem.

Identifying Pain Points: Pay particular attention to pain points or areas where the care experience may be suboptimal. These could include communication breakdowns, care coordination issues, access barriers, or gaps in service provision.

Developing Recommendations: Based on the analysis of the Atlas Care Map, develop recommendations for optimizing the care ecosystem. This may involve strategies for improving communication, enhancing care coordination, addressing resource constraints, or strengthening support networks.

Implementing Changes: Work collaboratively with stakeholders to implement the recommended changes. This may require coordination across multiple organizations and disciplines to ensure seamless integration of care services.

Monitoring and Evaluation: Continuously monitor the care ecosystem to track the impact of the implemented changes. Use metrics such as patient satisfaction, healthcare outcomes, and efficiency measures to evaluate the effectiveness of the interventions.

Atlas Care Mapping is designed to better understand and support family caregivers. It aims to shed light on the experiences, needs, and challenges faced by family caregivers through innovative research methods and data visualization techniques. For more information, visit: https://atlasofcaregiving.com/caremap/

NOTES:

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Geriatrics and Gerontology Education and Research

MISSION

The Geriatrics & Gerontology Education and Research Program

is a University of Maryland, Baltimore-based program that facilitates interprofessional education and interdisciplinary research activities in the field of aging in partnership with campus affiliates and agencies and organizations serving Maryland's older adults and their caregivers.

VISION Optimize care provided to older adults to promote quality of life through education, research, and training.

CORE VALUES

Accountability	Excellence
Civility	Diversity
Leadership	Knowledge
Collaboration	

Whether you want to make an impact directly by working with older adults and their families or indirectly through research, changing policy, or developing innovative technology to tackle the complex health and social challenges associated with growing older, a graduate degree from UMB is a great place to start.

Programs such as our graduate certificate in Aging & Applied Thanatology, our Master's in Gerontology, and our PhD in Gerontology are designed to help you meet your career goals. Visit our website for a complete list of academic programs.
Geriatrics and Gerontology Education and Research Program - UMB: An Age-Friendly University (umaryland.edu)

The Graduate School is home to the Geriatrics & Gerontology Education and Research (GGEAR) program. Educational programs developed by GGEAR and its partners include online training modules through Geri-ED and interprofessional training opportunities such as the Geriatric Assessment Interdisciplinary Team (GAIT) program, in which students learn and work collaboratively in interprofessional settings with a focus on rural and medically understand regions of Maryland.

For more information about the GGEAR Program or our offerings, please contact Diane Martin, Ph.D., Director, at diane.martin@umaryland.edu or 410-706-4327.

UNIVERSITY of MARYLAND GRADUATE SCHOOL
Geriatrics and Gerontology Education and Research

Maryland
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Spring 2024 "Navigating Dementia" Education Series Dates

Participant Registration Form

FOR WEBINARS, THE ZOOM LINK OPENS 30 MINUTES BEFORE THE START OF THE WEBINAR.

For example, webinar 1 opens at 12:30pm and begins promptly at 1:00pm.

Webinar 1: Friday, March 1, 2024 (12:30pm-3:00pm): Understanding Cognitive Aging: Differentiating Between Usual and Unusual Changes in Memory

Webinar 2: Friday, March 8, 2024 (12:30pm-3:00pm): Understanding Dementia: Differentiating Reversible and Irreversible Causes

In-Person Conference 1: Friday, March 22, 2024 (8:30am-4:00pm)The Meeting House, Columbia, MD: Health Literacy and Plain Language Communication in Alzheimer's and Related Dementia

Webinar 3: Friday, April 19, 2024 (12:30-3:00pm): Exploring Medical and Non-medical Interventions to Slow Cognitive Decline Associated with ADRD

Webinar 4: Wednesday, April 24, 2024 (10:30-12:30): Spectrum of Services & Supports in Maryland for Persons Living with Dementia (note: this webinar will be one of several offered during the annual caregiver's conference webinar hosted by Eastern Shore MAC, Inc. More information will be provided to individuals registering for this webinar held April 24 from 8:30am-3:00pm)

In-person Conference 2: Friday, May 10, 2024 (8:30am-4:00pm)The Meeting House, Columbia, MD: Assessment Tools Workshop: Tools & Referrals for Non-Clinicians

Webinar 5: Friday, May 24 (12:30pm-3:00pm): Empowering Caregivers: Essential Resources and Supports in Maryland

CEUs are available at no-cost for Certified Dementia Practitioners, Certified Senior Advisors, Maryland Social Workers, and Maryland Psychologists and Mental Health Professionals. Certificate of Attendance will be provided to all participants.

Plus, you can earn your Age-Friendly Specialist Certificate by attending our series.
Visit https://www.umaryland.edu/media/umb/geriatric-programs/GGEAR-AFU-Brochure.pdf for more details.