Total annual payments for health care, long-term care and hospice care for people with Alzheimer’s or other dementias are projected to increase from $259 billion in 2017 to more than $1.1 trillion in 2050. This dramatic rise includes more than four-fold increases both in government spending under Medicare and Medicaid and in out-of-pocket spending.

Health care costs increase with the presence of dementia. People with Alzheimer’s disease are hospitalized three times more often than seniors without Alzheimer’s.

Medicare beneficiaries with Alzheimer's or other dementias are more likely than those without dementia to have other chronic conditions.

Average per-person out-of-pocket costs for Alzheimer's and other dementias are almost five times higher than average per-person payments for seniors without these conditions.


Aggregate Cost of Care by Payment Source for Americans Age 65 and Older with Alzheimer's and Other Dementias, 2017*

Total Cost: $259 Billion (B)
- Medicare: $131 B, 51%
- Medicaid: $44 B, 17%
- Out of Pocket: $56 B, 22%
- Other: $28 B, 11%

*Data are in 2017 dollars.
Created from data from the Lewin Model. A21 “Other” payment sources include private insurance, health maintenance organizations, other managed care organizations and uncompensated care.
Cognitive impairment, while common in hospitalized elders, is under-recognized, impacts care, and increases risk for adverse health outcomes.


Nearly one in four hospitalized patients with dementia is readmitted within 30 days

We are already taking care of these patients. and we can continue to manage Alzheimer’s as one of co-occurring diagnosis and improve outcomes.

Can we also see these patients if the primary diagnosis is Alzheimer’s?

Yes, if they have a caregiver to teach (family member, friend, paid caregiver) and a skilled need.
Cognitive Impairment: Normal Aging versus ADRD

<table>
<thead>
<tr>
<th>Normal Aging</th>
<th>ADRD</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Minor memory lapses or forgetfulness of part of an experience</td>
<td>- Misplacement of important items</td>
</tr>
<tr>
<td>- Occasional lapses in attention or concentration</td>
<td>- Trouble doing simple tasks</td>
</tr>
<tr>
<td>- Appropriate sadness/anxiety</td>
<td>- Trouble with arithmetic</td>
</tr>
<tr>
<td>- Changing interests</td>
<td>- Trouble making routine decisions</td>
</tr>
<tr>
<td>- Increase in cautious behavior</td>
<td>- Confusion about month or season</td>
</tr>
<tr>
<td>- Unimpaired language skills</td>
<td>- Mood changes</td>
</tr>
<tr>
<td>- Slower reaction times</td>
<td>- Decrease interest in outside activities</td>
</tr>
<tr>
<td></td>
<td>- Denial of symptoms</td>
</tr>
</tbody>
</table>

ADRD = Alzheimer’s Dementia and Related Dementias

- AD and ADRD has a profound effect on memory, executive processing and behavior which complicates management of chronic conditions

- Recognize non-compliance may be a cognitive issue and document with Evidence based testing

Example: Mini COG less than 5 minutes to administer
Steps to simplify and manage other chronic conditions: Caregiver teaching/ Self management/Proactive care:

Med minders
White boards
High visibility clocks
Cell phone alarms
Apps that speak reminders
Environmental Modifications

What can we do to educate the caregiver?

Teach the caregiver

- To enter the world of the individual with Alzheimer’s disease.
- To understand that world and be willing to change without expectations that the person with AD will change.
- What is cognitively/functionally appropriate for the person with AD.
A QUICK TRIP THROUGH THE BRAIN

- **First hippocampus** – stores short term memory by middle stage - 5 minutes of short term memory NO NEW LEARNING.
- **Parietal lobes** - where spatial processing is housed - problems in perception as well as in navigating unfamiliar locations. LIKE GPS.
- **Temporal lobes** - control time awareness and language - word finding problems.
- **Occipital lobe** – can’t identify things that are seen, misuse of objects, trouble understanding and thinking very concrete.
- **Limbic system** - emotional roller coaster.
- **Hypothalamus** – temperature and appetite control.
- **Motor Strip** – walking, sitting up, continence, swallowing.

THEORY OF RETROGENESIS

The Reversal of Normal Human Development

<table>
<thead>
<tr>
<th>Handles Simple Finances</th>
<th>Early Stage Mild Dementia Cognitive Age: 8-12 years old</th>
<th>Requires help with complex tasks: menu planning handling finances,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selects proper clothing and puts on clothing unaided</td>
<td>Middle Stage Moderate Dementia Cognitive Age: 5-11 years old</td>
<td>Help with selecting and putting on clothes</td>
</tr>
<tr>
<td>Goes to the Bathroom unaided</td>
<td>Late Middle Stage Moderately Severe Dementia Cognitive Age: 2-4 years old</td>
<td>Needs help with toileting</td>
</tr>
<tr>
<td>Infant/Baby Holds Head up and Smiles</td>
<td>Late Stage Severe Dementia Cognitive Age: Newborn-18mo.</td>
<td>Unable to Hold Head up or Smile</td>
</tr>
</tbody>
</table>

Once an Adult..... ➢ All that we learn going forward

Twice a Child..... ➢ We repeat again going backwards

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Stages Of Alzheimer’s Disease

<table>
<thead>
<tr>
<th>First (Early) Stage</th>
<th>Second (Middle) Stage</th>
<th>Third (Late) Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lasts 2-4 years –up to and including dx</td>
<td>Lasts 2-10 years</td>
<td>Lasts 1-3 years</td>
</tr>
<tr>
<td>May live alone or with little supervision</td>
<td>Longest stage</td>
<td>Palliative Care</td>
</tr>
<tr>
<td></td>
<td>Needs full-time Supervision</td>
<td>May receive Hospice Care</td>
</tr>
</tbody>
</table>

Think about a young adolescent when planning approaches. Consider the judgment and responsibility of an 11 year old deteriorating to that of a 5 year old. Repetition and reminders work at this stage.

Think about a toddler. What is a 4 deteriorating to a 2 year old capable of doing? How do you supervise a toddler? How much care is needed? Safety issues very important.

Think about an 18 month old to a newborn - what does this age need; how much care is involved; how does baby communicate needs? Total care most likely needed due to total body shut down.

Second (Middle) Stage Abilities

- Able to initiate familiar activity if supplies are available and in reach
- Able to do steps of self care with verbal and tactile cues
- Able to tell stories from past
- Able to read words slowly out loud
- Able to follow slow simple instructions
- Able to speak in short sentences or phrases; able to make needs known
- Able to sort, stack objects and do repetitive behaviors
- Able to sing, move to music, count
- Able to ambulate if no physical disability
- Able to feel and name objects
Second Stage: 2 - 10 years after dx, longest stage

Disabilities

- Needs full-time Supervision
- Problems recognizing family and friends
- Problems organizing thoughts/logical thinking
- Repeats statements and/or movements
- Trouble dressing – may not want to bathe
- Increasing disorientation and forgetfulness
- Can’t find words – confabulates
- Suspicious, teary, fidgety, irritable, silly
- Challenging behaviors become apparent

Behaviors

- Physical Discomfort
- Loud Noises Hectic Environment
- Unfamiliar Surroundings
- Difficulty with Tasks
- Inability to Communicate
Specific Challenging Behaviors That Lead to Hospitalization

- Sleep Disturbances
- Resistance to Care
- Agitation & Aggression
- Wandering
- Unaddressed Pain
- WHAT SHOULD WE DO? THINK CAUSE OF BEHAVIOR

Process for Problem Solving: Interventions

Behavior – what, when, how is person behaving?

A. Potential Physical Causes
   a. Pain**-arthritis, UTI, constipation/impaction
   b. Hunger
   c. Dehydration
   d. Fatigue
   e. Unmet physical needs
   f. Depressed

Always consider physical issues –especially pain first. Often times behaviors are a persons way of communicating something.
PAIN 5th Vital Sign

- A detailed assessment at admission and assessed at every assessment
- How is it manifested
  - Behaviors-non-verbal responses, limitations in movement, sleep
  - Activities patient has stopped performing due to pain
  - Verbalization
- Look at History
  - Previous meds
  - Talk with family
  - Arthritis
- Assessments
  - PAINAD
  - FACES
Numeric Pain Scale/FACES Pain Scale

1. (Name of patient) are you having any pain today? 2. Please rate your pain on a zero to ten scale with zero being no pain and ten as the worst pain you can imagine. Point to face that best describes your pain. (Show the patient the pain scale) 3. You have reported a pain score of 6 (≥ 4). This is a significant level of pain; I want to discuss this with your doctor or nurse practitioner today.

Sleep Disturbances

What is the cause?

- Decreased Activity/Boredom
- Sleeping too much during daylight hours
- Upset in the normal routine
- Pain/Discomfort
- Too many stimulants in late afternoon
Solutions to Encourage Sleep

- Increase daily exercise
- Encourage stimulating activities and chores throughout the day
- Discourage late afternoon napping
- Ensure morning sunlight or bright light exposure in the morning hours, keep the home well lit in the evening
- Assure that the sleeping environment is comfortable and safe, keep the temperature comfortable for sleeping
- Use weighted blankets
- Try a body pillow, if individual had always slept with another
- Maintain consistent routine-times for Meals, Wake time and Bedtime

Solutions to Encourage Sleep con’t

- Avoid stimulants in late afternoon and evening- Nicotine, Caffeine, and Sweets
- Serve large meals early in the day not evening
- Treat pain prior to bedtime
- Replicate the individual’s past routine- Did they always have warm milk and listen to soft music before retiring for the day?
- Aromatherapy to increase relaxation
- Play soft music, try a back rub, foot or shoulder massage to relax the individual
- Place the commode near the bed, if toileting is an issue at night
- Limit environmental distraction in the evening hours (TV, loud music, visitors etc.)
# Resistance to Care @ Bathing

## CAUSES
- **Pain**
- **Room too cold**
- **Overhead shower – causes fear**

## RESPONSES
- Treat Pain – i.e. medicate with Tylenol ½ - 1 hour before bath
- Keep patient covered; make sure bathroom area warm
- Sponge bath, use handheld shower, bathe in chair, bed, standing up
- Use candy, music or other distraction

## Bathroom modifications
- Install flooring with texture
- Visible toilet seat/ bowl (change color of toilet seat to contrast with toilet bowl), purchase illuminated toilet bowl
- Toilet paper that is a different color than the holder, walls and floor
- Increase height of the vanity
- Remove glass and mirrors
- Install lighting to ensure room is properly lit.
- Maintain visual organization- commonly used items are clearly visible
- Organize by category e.g.: hairbrush, comb, brush
  
  Cup, toothbrush, toothpaste
Bathing tips

- Create a spa like experience
- Consider bathing options
- Seated on toilet covered with warm towel
- Standing or seated at the sink
- Use familiar products ex: Ivory soap
- Bright colored towels/easy for individual to see
- Label the cupboards and drawers

Caregiver Education

- Teach the Stages of Alzheimer’s
- Figure out causes of Behaviors
- Utilize strategies to solve the behaviors
  - Increase patient quality of life
  - Decrease caregiver stress
- Increase ability to deal with other co-morbidities
  - Decrease Hospitalizations
  - Decrease Costs
  - Increase overall quality of care delivered
BECOMING AN ALZHEIMER’S WHISPERER: A LOVING AND GENTLE APPROACH TO CHALLENGING BEHAVIORS

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