Welcome!

Thank You, Partners:

GOBHI

Central Oregon Health Council

BUILDING PARTNERSHIPS FOR OLDER ADULT BEHAVIORAL HEALTH

Disclosures

- Nirmala Dhar has no conflicts to disclose

- Audio and video are muted for all attendees.
- Select ··· to populate the Chat feature to your right. Please ask session questions using the Q&A featured and use the Chat function for everything else.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/forum-aging-rural-oregon.
- If you'd like the CEU for this session, please complete the survey.

Presents,

Let's Talk About Dementia

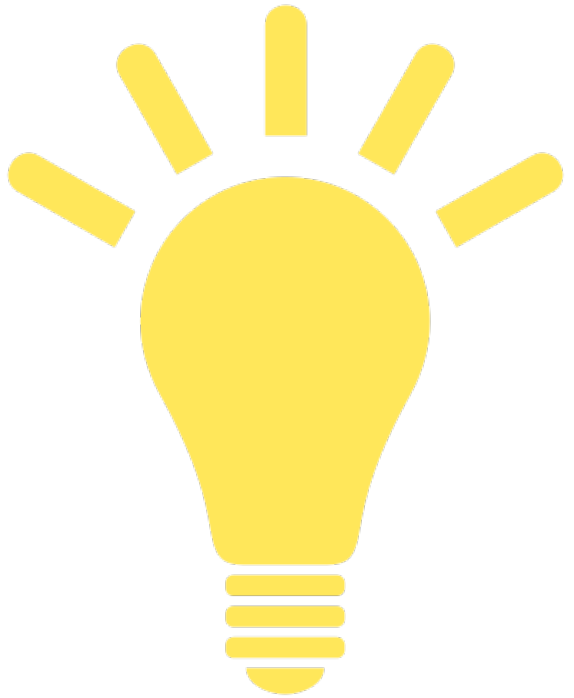
Speaker:

Nirmala Dhar, LCSW| Older Adult Behavioral Health Project Director| Oregon Health Authority

Learning Objectives

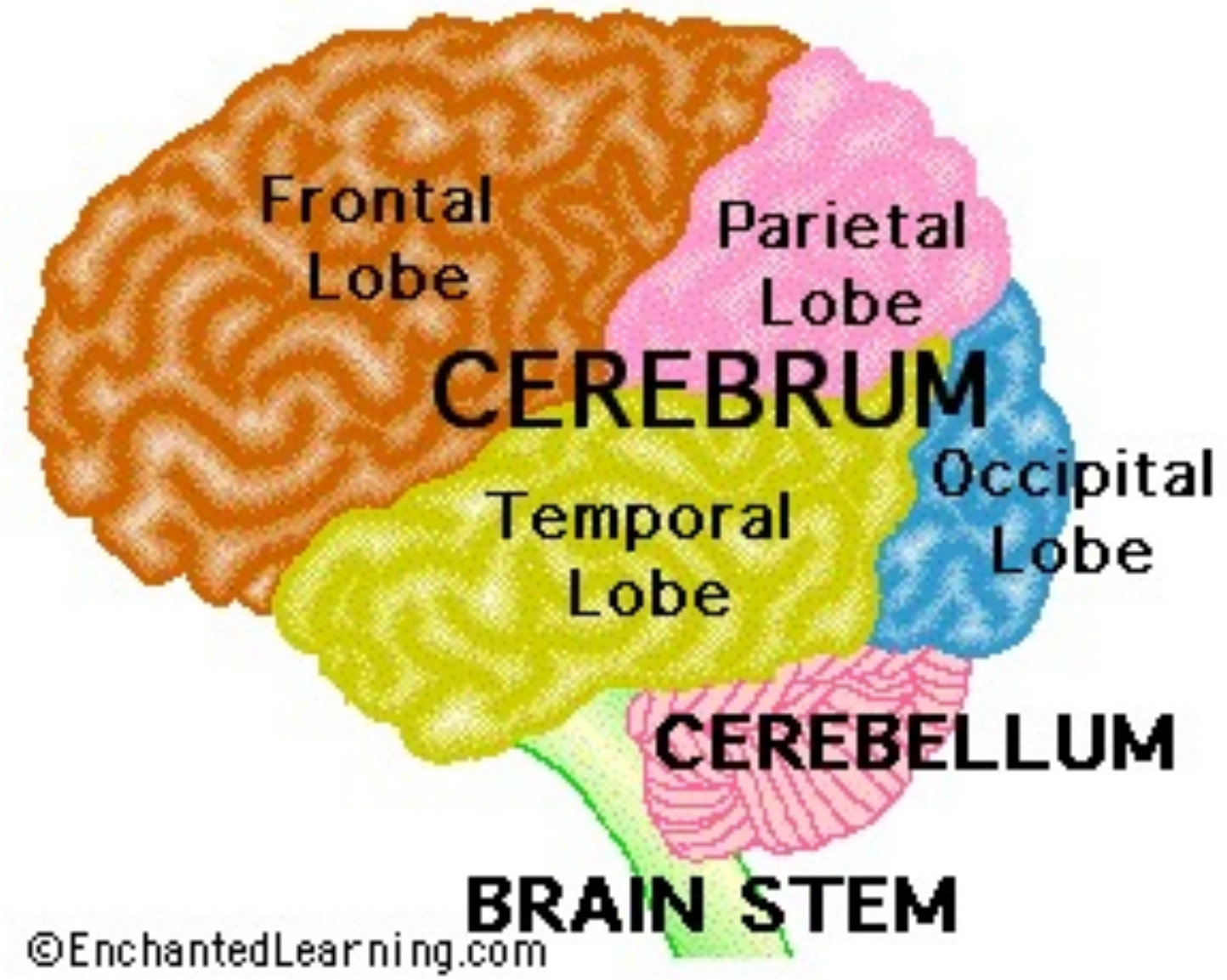
After attending this session, participants will have:

- ✓Knowledge of symptoms of Alzheimer's Disease and other dementias
- ✓Knowledge of how caregivers are impacted
- ✓Knowledge of dementia and elder abuse
- ✓Information on resources for your loved one and for family caregivers

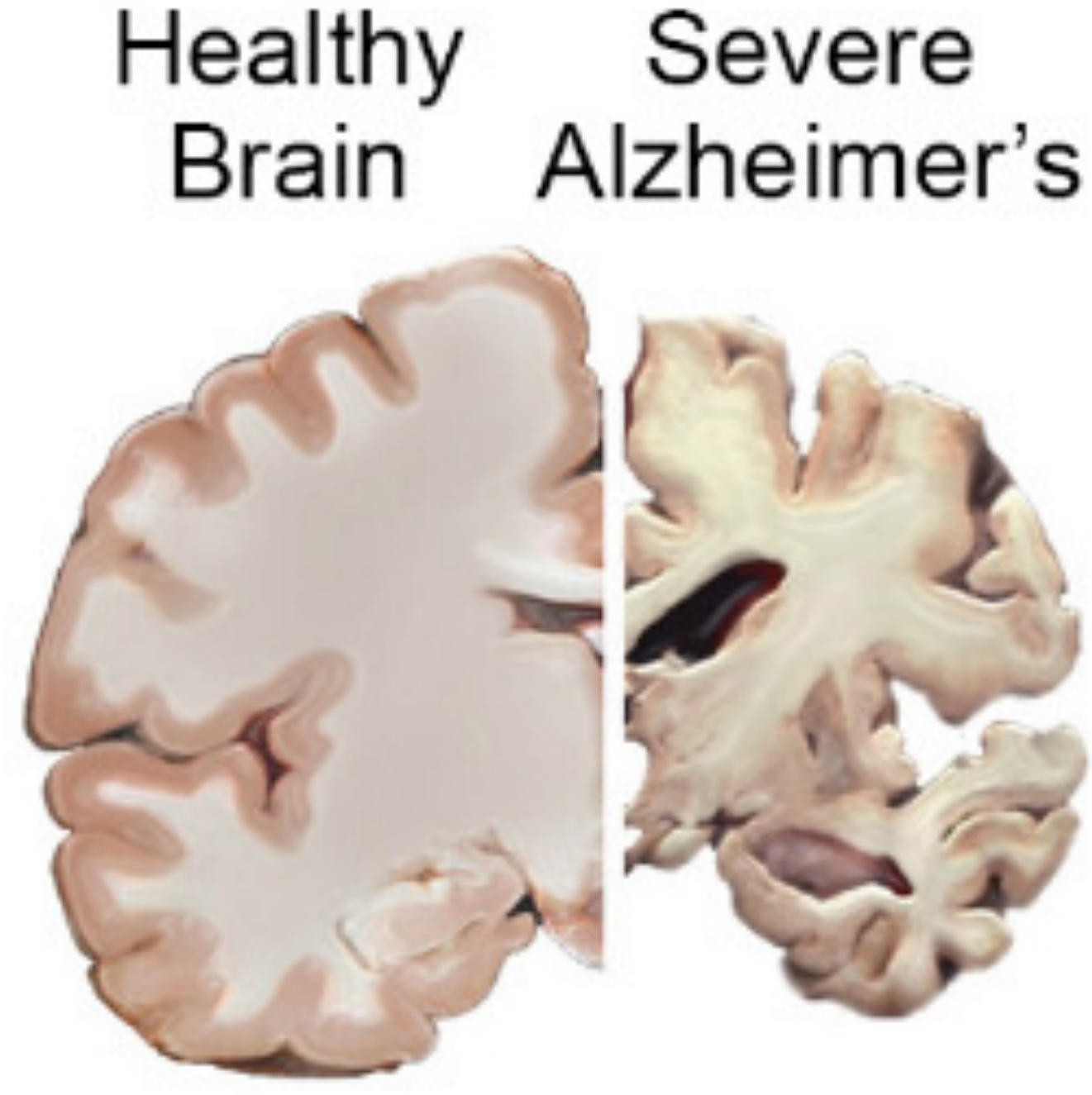


Dementia

- A BRAIN DISEASE
- IT IS PROGRESSIVE
- IT IS IRREVERSIBLE
- CURRENTLY NO CURE
- THE TOP 10 LEADING CAUSES OF DEATH IN THE UNITED STATES



Dementia is a brain disease



Dementia: Facts and Figures

- *Prevalence, Incidence and Mortality*
- An estimated 6.2 million Americans age 65 and older are living with Alzheimer's dementia in 2021.
- More than 1 in 9 people (11.3%) age 65 and older has Alzheimer's dementia.
- Two-thirds of Americans over age 65 with Alzheimer's dementia (3.8 million) are women.
- Deaths due to Alzheimer's between 2000 and 2019 has more than doubled, increasing 145%.
- 1 in 3 seniors dies with Alzheimer's or another dementia.

https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf - 2021

OREGON ALZHEIMER'S STATISTICS

- 2020 69,000
- 2025 84,000
- 21.7% - ESTIMATED INCREASE IN FIVE YEARS!

https://www.alz.org/media/Documents/oregon-alzheimers-facts-figures-2021.pdf

2021 ALZHEIMER'S DISEASE FACTS AND FIGURES

- While deaths from Alzheimer's disease have INCREASED 145% Between 2000 and 2019, deaths from heart disease have DECREASED 7.3%.
- It kills more than BREAST CANCER + PROSTATE CANCER COMBINED
- MORE THAN 6 MILLION Americans are living with Alzheimer's
- DISCRIMINATION is a barrier to Alzheimer's and dementia care. These populations reported discrimination when seeking health care: 50% of Black Americans 42% of Native Americans 34%
- Alzheimer's and dementia deaths have increased 16% during the COVID-19 pandemic

Differences Between Women and Men in the Prevalence and Risk of Alzheimer's and Other Dementias

- More women than men have Alzheimer's or other dementias. Almost two-thirds of Americans with Alzheimer's are women. Of the 6.2 million people age 65 and older with Alzheimer's in the United States, 3.8 million are women and 2.4 million are men. This represents 12% of women and 9% of men age 65 and older in the United States.
- These differences may be based in biology such as chromosomal or hormonal differences (i.e., sex differences) or differences in environmental, social and cultural influences on men and women (i.e., gender differences), or the combination of the two

Race, Ethnicity, and Alzheimer's

Whites make up the majority of the over 5 million people in the United States with Alzheimer's.

But, combining evidence from available studies shows that African Americans and Hispanics are at higher risk.

African Americans are about two times more likely than white Americans to have Alzheimer's and other dementias.

Hispanics are about one and one-half times more likely than whites to have Alzheimer's and other dementias.

https://www.alz.org/aaic/downloads2020/2020_Race_and_Ethnicity_Fact_Sheet.pdf

Race/Ethnic Disparities

- While African Americans are about two times more likely than whites to have Alzheimer's and other dementias, they are only 34% more likely to have a diagnosis.
- Hispanics are about one and one-half times more likely than whites to have Alzheimer's and other dementias, but they are only 18% more likely to be diagnosed.

Underdiagnosis of Alzheimer's and Other Dementias in the Primary Care Setting

- Since 2011, the Medicare Annual Wellness Visit has included a required cognitive evaluation. A survey by the Alzheimer's Association found that only 1 in 3 older adults were aware that these visits should include a cognitive assessment.
- Furthermore, while 82% of older adults believe it is important to have their memory and thinking checked, only 16% report having their memory and thinking checked.
- Most (93%) older adults said they trust their doctor to recommend testing for memory and thinking problems; however, despite 94% of primary care physicians stating that it is important to assess all older patients for cognitive impairment, fewer than half (47%) say it is their standard protocol to do so.
- The primary reasons given by surveyed physicians for not assessing older patients for cognitive impairment are (1) the patient presents with no symptoms or complaints (68%) and (2) lack of time (58%).

Why Primary Care?

- Often first to address a patient's compliant or family's concern about memory loss.
- With the use of cognitive screening tools you can identify emerging cognitive deficits, possible causes, follow up with treatment for what may be a reversible health condition; or if dementia is found you can help your patient and their caregivers prepare for the future

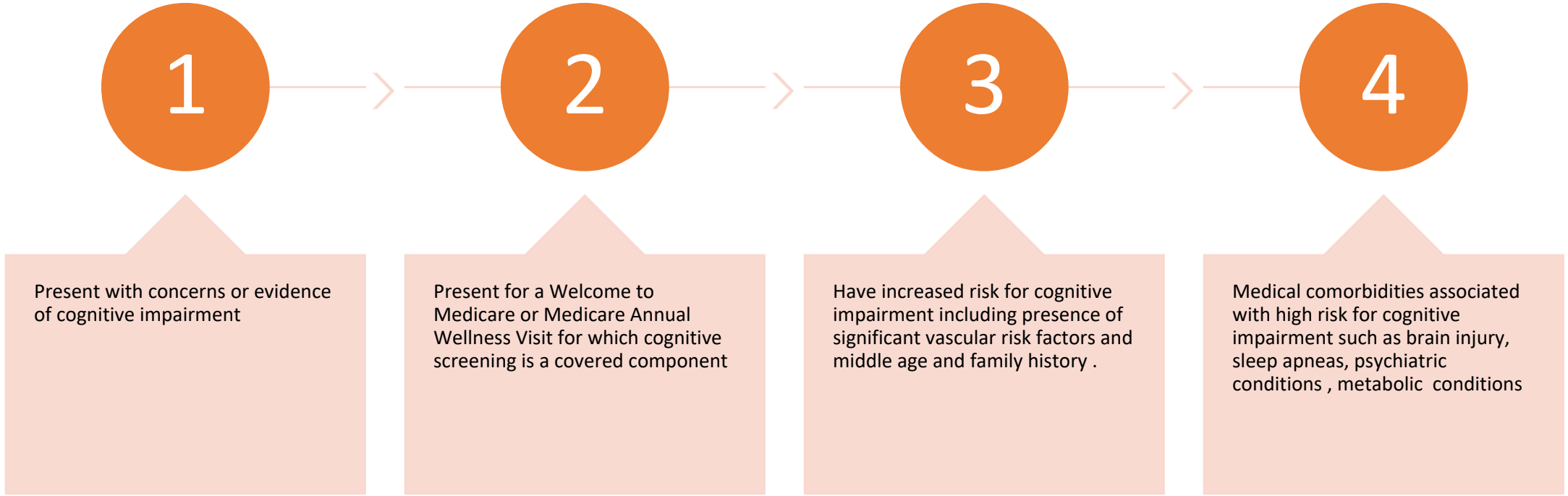
ASK ABOUT MEMORY AND COGNITION

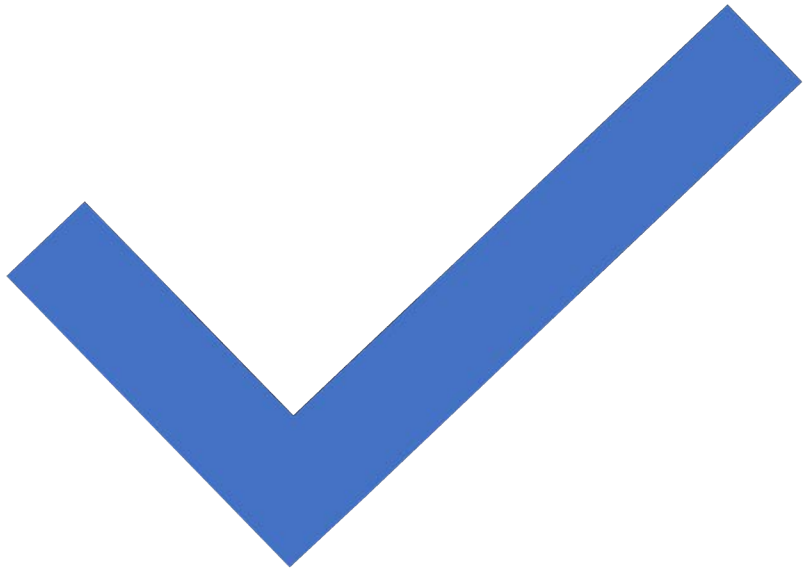
"Are you worried about your memory?"

Have you noticed a change in your memory that concerns you?"

"During the past few months have you had increasing problems with your memory?"

OPPORTUNITIES FOR SCREENING





Benefits of Early Detection

- A better chance of benefiting from treatment
- More time to plan for the future
- Lessened anxieties about unknown problems
- Increased chances of participating in clinical drug trials, 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
- Benefit from care and support services, making it easier for them and their family to manage the disease

NORMAL AGING VS DEMENTIA

NORMAL AGING

- Independence preserved
- Complains of memory loss but cannot give details
- Person is more concerned about alleged memory loss
- Occasional word finding problems
- Does not get lost
- Normal performance on mental status tests

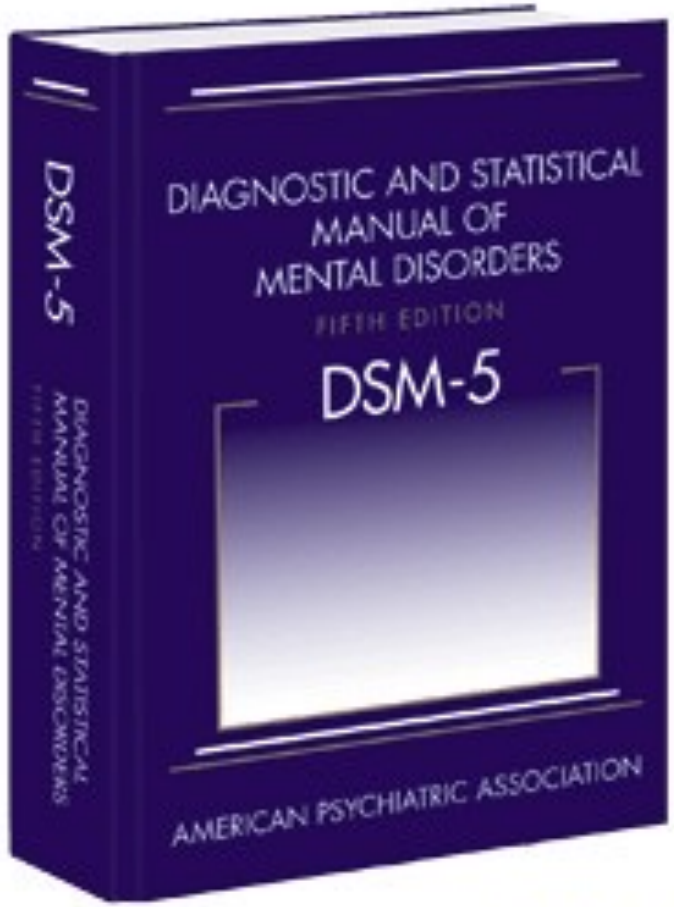
DEMENTIA

- Dependent on others for living activities
- May complain of memory problems only when asked
- Family members more concerned about incidents of memory loss
- Frequent word finding problems
- Gets lost in familiar areas
- Abnormal on MMSE

DSM V AND DEMENTIA
Neurocognitive disorder

- NEUROCOGNITIVE DISORDER
- DECLINE FROM A PREVIOUS LEVEL OF FUNCTIONING IN ONE OR MORE OF 6 COGNITIVE DOMAINS:

1. Executive Ability
2. Language
3. Learning and Memory
4. Perceptual Motor
5. Social Cognition
6. Complex Attention



DSM V NEUROCOGNITIVE DISORDER

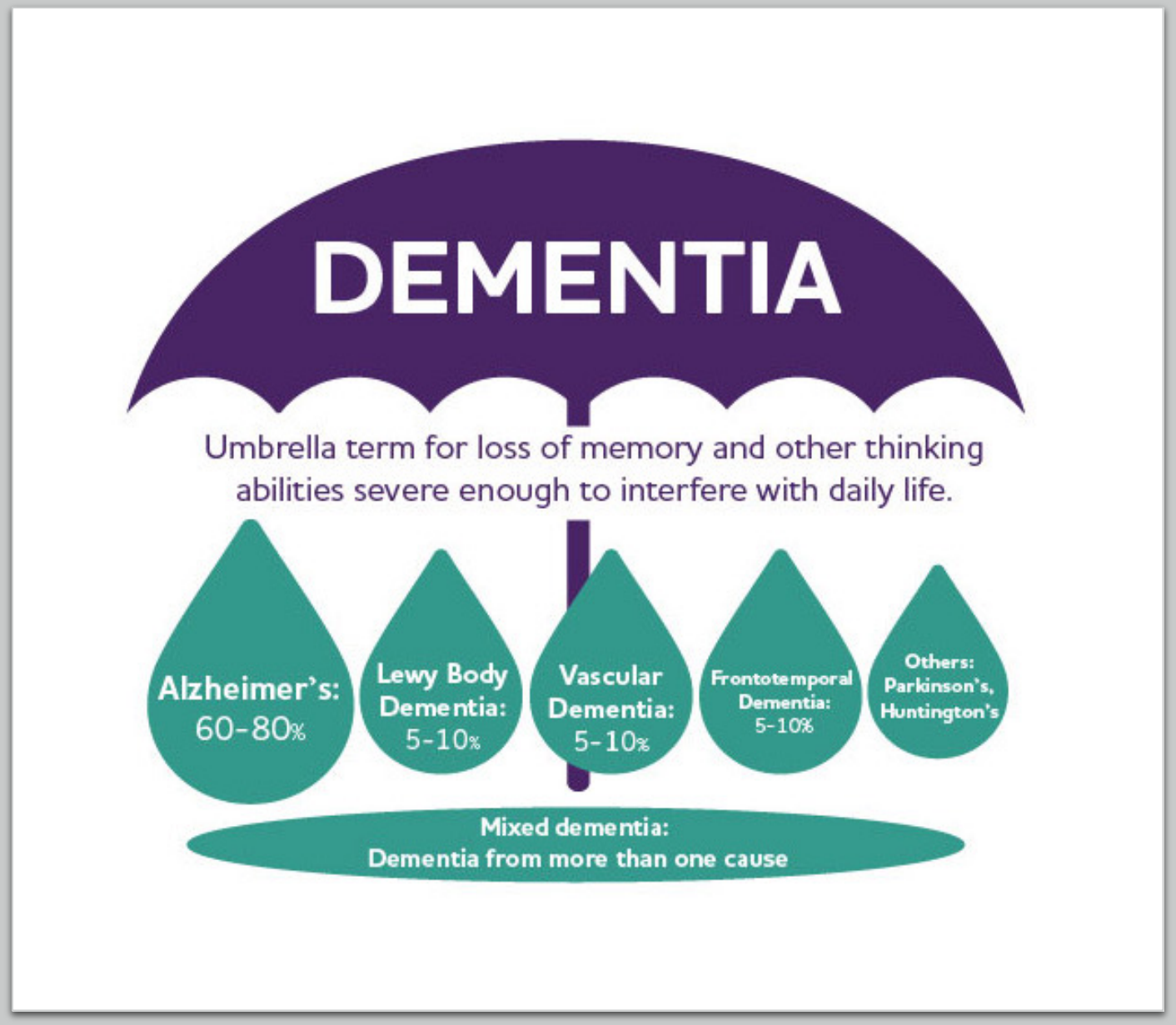
THE COGNITIVE DEFICITS INTERFERE WITH INDEPENDENCE IN EVERYDAY ACTIVITIES

THESE DEFICITS DO NOT APPEAR IN THE CONTEXT OF A DELIRIUM

THESE DEFICITS ARE NOT EXPLAINED BY ANY OTHER MENTAL DISORDER (MAJOR DEPRESSION, SCHIZOPHRENIA)

DEMENTIA IS AN UMBRELLA TERM

- Dementia is not a single disease; it's an overall term — like heart disease — that covers a wide range of specific medical conditions, including Alzheimer's disease.



https://www.alz.org/alzheimers-dementia/what-is-dementia

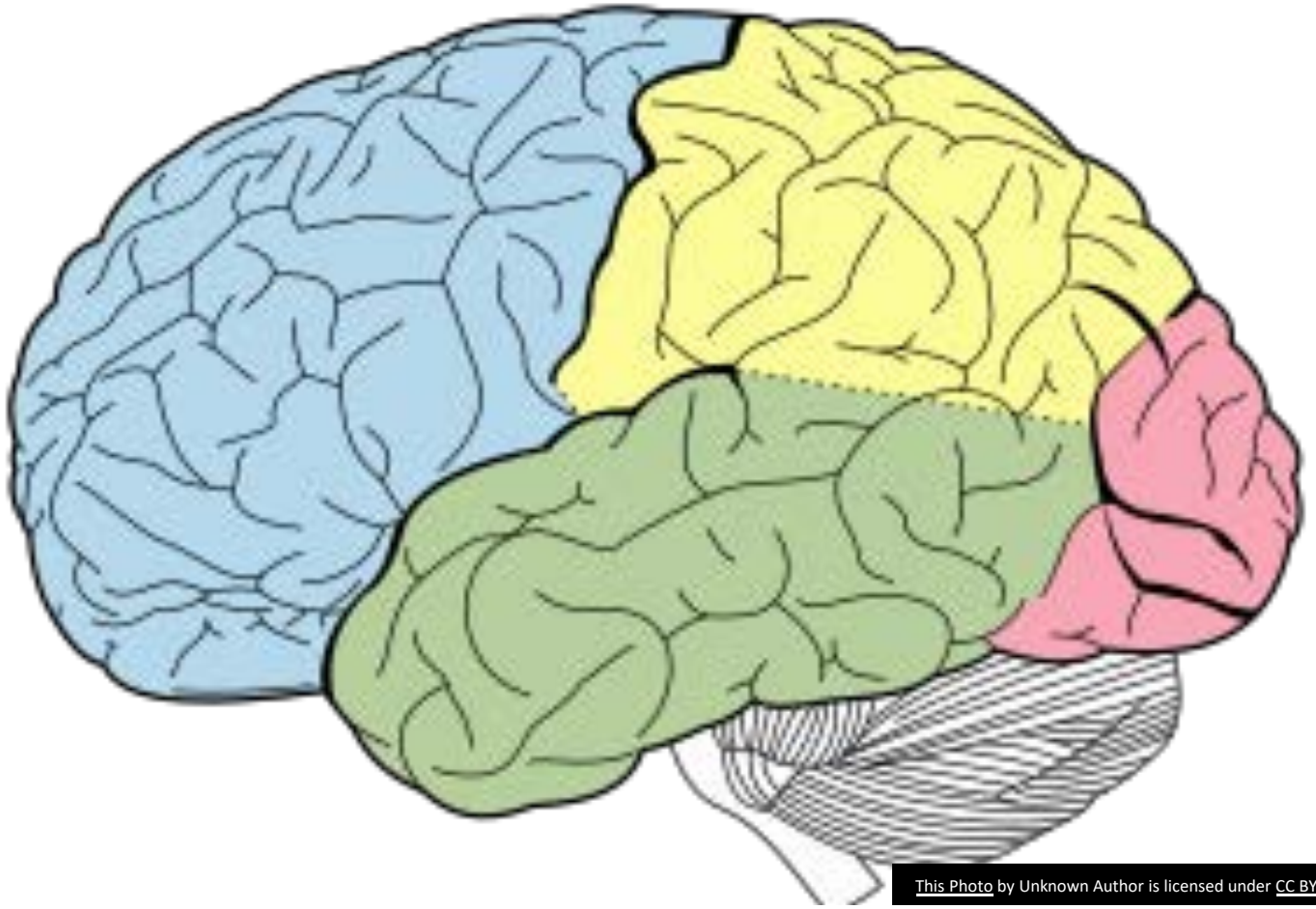
What is Alzheimer's Disease?

- Alzheimer's disease is a type of brain disease, just as coronary artery disease is a type of heart disease. It is also a progressive disease, meaning that it becomes worse with time. Alzheimer's disease is thought to begin 20 years or more before symptoms arise.1-8 It starts with changes in the brain that are unnoticeable to the person affected. Only after years of brain changes do individuals experience noticeable symptoms such as memory loss and language problems.

Alzheimer's Association. 2021 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2021;17(3).

Brain Functions that are affected

- Memory and learning
- Language – ability to understand and or communicate
- Attention
- Judgement
- Reasoning
- Speed of processing
- Visual/perceptual/motor
- Executive functioning



Signs & Symptoms of Dementia

- Memory loss that disrupts daily life: One of the most common signs of Alzheimer's dementia is memory loss, especially forgetting recently learned information. Others include forgetting important dates or events, asking for the same information over and over, and increasingly needing to rely on memory aids (for example, reminder notes or electronic devices) or family members for things that used to be handled on one's own
- Challenges in planning or solving problems: Some people experience changes in their ability to develop and follow a plan or work with numbers. They may have trouble following a familiar recipe, keeping track of monthly bills or counting change. They may have difficulty concentrating and take much longer to do things than they did before.
- Difficulty completing familiar tasks at home, at work or at leisure: People with Alzheimer's often find it hard to complete daily tasks. Sometimes, people have trouble driving to a familiar location, managing a budget at work or remembering the rules of a favorite game.

Signs and Symptoms of Dementia

- Confusion with time or place: People with Alzheimer's can lose track of dates, seasons and the passage of time. They may have trouble understanding something if it is not happening immediately. Sometimes they forget where they are or how they got there.
- Trouble understanding visual images and spatial relationships: For some people, having vision problems is a sign of Alzheimer's. They may have difficulty reading, judging distance and determining color or contrast, which may cause problems with driving.
- New problems with words in speaking or writing: People with Alzheimer's may have trouble following or joining a conversation. They may stop in the middle of a conversation and have no idea how to continue or they may repeat themselves. They may struggle with vocabulary, have problems finding the right word or call things by the wrong name (e.g., calling a watch a "hand clock")

Signs and Symptoms of Dementia

- Misplacing things and losing the ability to retrace steps: People with Alzheimer's may put things in unusual places and lose things and be unable to go back over their steps to find them again. Sometimes, they accuse others of stealing. This may occur more frequently over time.
- Decreased or poor judgment: People with Alzheimer's may experience changes in judgment or decision-making. For example, they may use poor judgment when dealing with money, giving large amounts to telemarketers. They may pay less attention to grooming or keeping themselves clean.

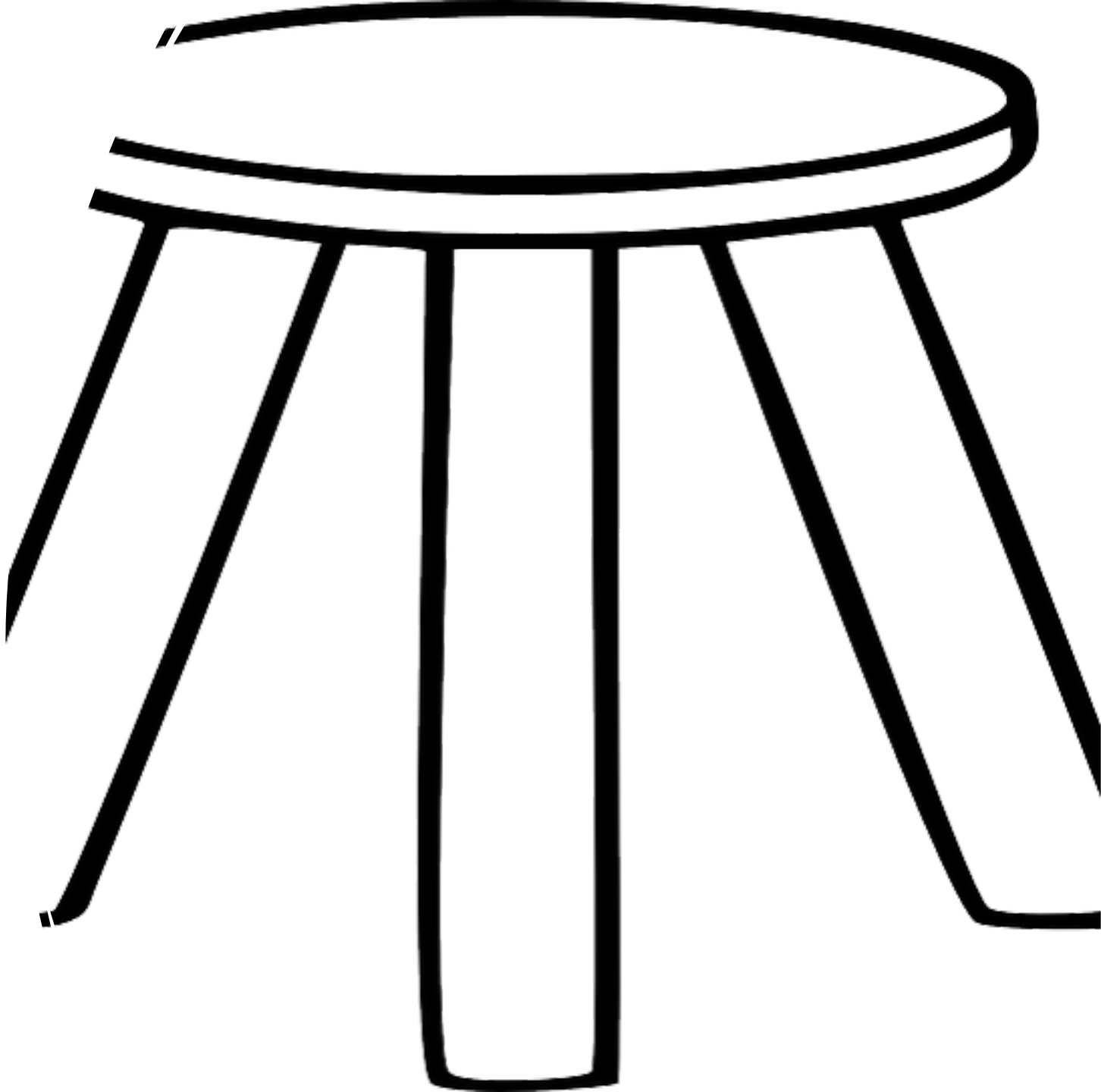
Signs and Symptoms of Dementia

- Withdrawal from work or social activities: People with Alzheimer's may start to remove themselves from hobbies, social activities, work projects or sports. They may have trouble keeping up with a favorite sports team or remembering how to complete a favorite hobby. They may also avoid being social because of the changes they have experienced. Sometimes feeling weary of work, family and social obligations.
- Changes in mood and personality: The mood and personalities of people with Alzheimer's can change. They can become confused, suspicious, depressed, fearful or anxious. They may be easily upset at home, at work, with friends or in places where they are out of their comfort zones.

DEMENTIA: Three legs of a stool

DEMENTIA IS A COMBINATION OF:

- ✓ Cognitive decline
- ✓ Functional decline
- ✓ Behavioral Impact



HOW DO YOU ASSESS FUNCTIONAL IMPAIRMENT?

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL's)

ACTIVITIES OF DAILY LIVING (ADL'S)

Symptoms

Initially trouble with instrumental activities of daily living (IADL's) such as managing money, paying bills preparing meals taking medications.

With progression person cannot perform basic activities called activities of daily living (ADL) such as personal hygiene, feeding themselves, getting dressed and toileting.

Instrumental activities of daily living

- **IADL Function Independent Needs Help Dependent Cannot Do**
- Shopping
- Cooking
- Managing medications
- Using the phone and looking up numbers
- Doing housework
- Doing laundry
- Driving or using public transportation
- *Managing finances

ACTIVITIES OF DAILY LIVING

- **ADL Function Independent Needs Help Dependent Cannot Do**
- Bathing
- Dressing
- Grooming
- Mouth care
- Toileting
- Transferring bed/chair
- Walking
- Climbing stairs
- Eating

NEUROPSYCHIATRIC SYMPTOMS

- NEUROPSYCHIATRIC SYMPTOMS (NPS) ARE ALMOST UNIVERSAL IN DEMENTIA
- THESE SYMPTOMS CAUSE CAREGIVERS AND PEOPLE LIVING WITH DEMENTIA THE MOST QUALITY OF LIFE IMPAIRMENT
- PSYCHOTIC SYMPTOMS IN DEMENTIA:
- ALZHEIMER'S = 30%; LEWY BODY DEMENTIA = 75%; PARKINSON'S DEMENTIA=50%; VASCULAR DEMENTIA = 15%; FROTOTEMPORAL DEMENTIA=10%

Hallucinations and Delusions

Actor portrayal

Hallucination

Perception-like experience that occurs without an external stimulus; sensory in nature

"I hear someone talking to me in my head."

"There is a cat walking through the kitchen."

"I see my parents in the corner."

Delusion

False, fixed belief despite evidence to the contrary

"People are talking about me."

"Someone keeps stealing my things."

"There's a new person who lives in my basement."

Actor portrayal

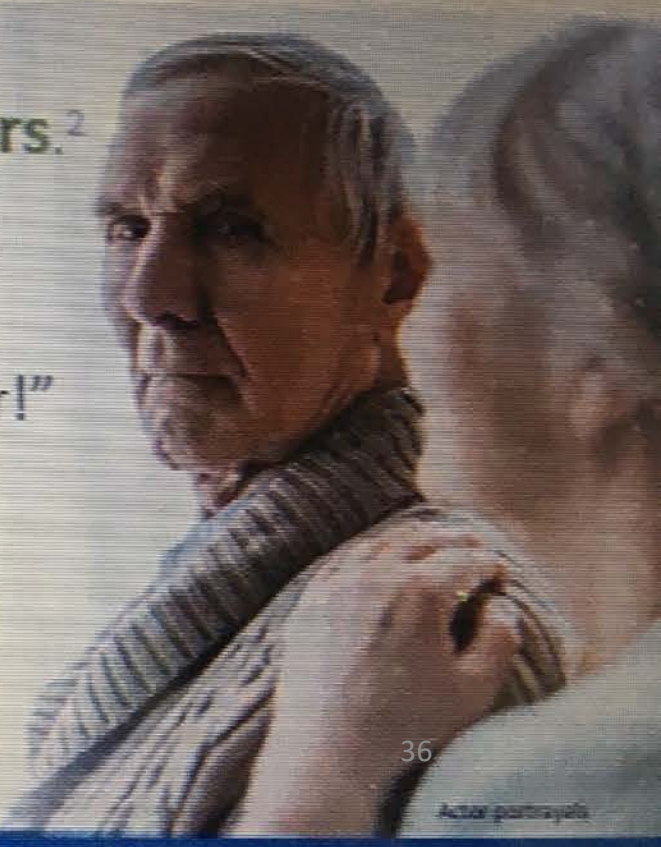
American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: American Psychiatric Publishing; 2013.

The Burden of Dementia Typically Falls on Family Caregiver

Approximately **70%** of older adults with dementia **receive support from family caregivers**[1,*]

Common delusions in dementia **target the family caregivers**.[2]

- **Theft:** "You're stealing my things!"
- **Abandonment:** "You're going to abandon me!"
- **Capgras syndrome:** "You're not my spouse. You're an imposter!"
- **Spousal infidelity:** "You're having an affair!"



*Data from the 2015 National Health and Aging Trends Study and its companion study, the National Study of Caregiving; population-based analysis included 2417 people with dementia aged ≥65 years who received help with self-care, mobility, or household activities and their 2204 family caregivers.

1. Chi W, et al. *Older Adults With Dementia and Their Caregivers: Key Indicators From the National Health and Aging Trends Study*. Washington, DC: The Office of the Assistant Secretary for Planning and Evaluation; January 2019.
2. Ballard C, et al. *Int J Geriatr Psychiatry*. 1995;10(6):477-485.

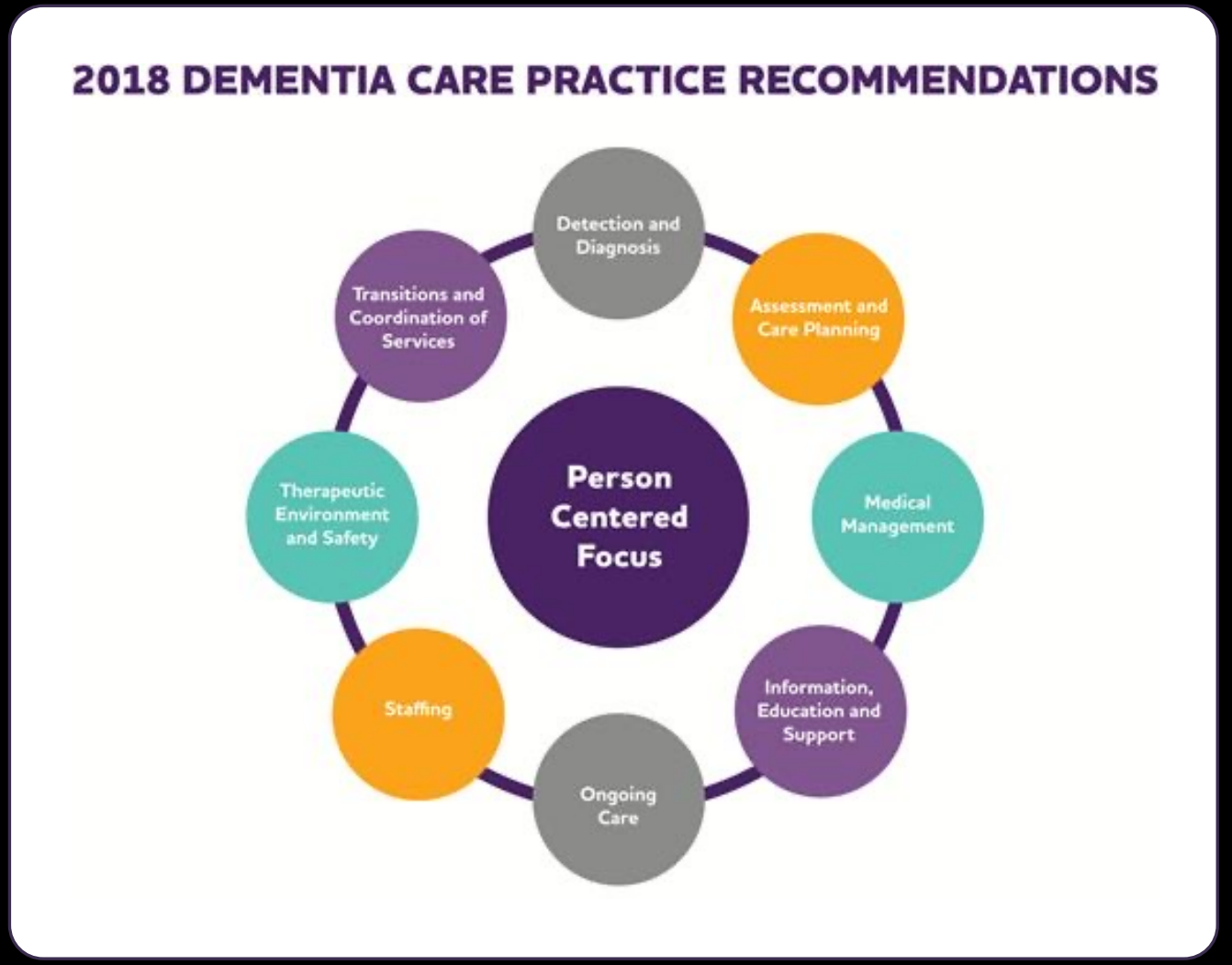
Inouye SK et al. Arch Intern Med. 2001;161:2467-2473

BEHAVIORAL EXPRESSIONS/ CHALLENGES IN DEMENTIA

- NON-PHARMACOLOGICAL APPROACHES SHOULD ALWAYS BE THE FIRST LINE APPROACH FOR BEHAVIORAL EXPRESSIONS IN DEMENTIA.
- BEHAVIOR IS AN EXPRESSION OF AN UNMET NEED – WHAT IS NOT BEING MET? WHAT IS BEING COMMUNICATED?
- SEEK TO UNDERSTAND – BECOME A DETECTIVE.
- “THEY ARE DOING THEIR VERY BEST….”
- UNDERSTAND BEHAVIOR NOT CONTROL IT.
- ACCEPT BEHAVIOR THAT IS NOT DANGEROUS BUT MAY BE DIFFICULT.

Best Practice

- **Alzheimer's Association Dementia Care Practice Recommendations**



Who are the caregivers?

- Approximately two-thirds of dementia caregivers are women.

- About 30% of caregivers are age 65 or older.

- Over 60% of caregivers are married, living with a partner or in a long-term relationship

https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf

Caregiving and Women

- The responsibilities of caring for someone with dementia often fall to women.
- As mentioned earlier, approximately two-thirds of dementia caregivers are women.
- Over one-third of dementia caregivers are daughters.
- It is more common for wives to provide informal care for a husband than vice versa.
- On average, female caregivers spend more time caregiving than male caregivers

CAREGIVER'S BILL OF RIGHTS

- I have the right: To take care of myself. This is not an act of selfishness. It will enable me to take better care of my loved one.
- I have the right: To seek help from others even though my loved one may object. I recognize the limits of my own endurance and strength.
- I have the right: To maintain facets of my own life that do not include the person I care for, just as I would if he or she were healthy. I know that I do everything that I reasonably can for this person, and I have the right to do some things for myself.
- I have the right: To get angry, be depressed and express other difficult emotions occasionally. I have the right: To reject any attempt by my loved one (either conscious or unconscious) to manipulate me through guilt, anger or depression.
- I have the right: To receive consideration, affection, forgiveness and acceptance from my loved one for as long as I offer these qualities in return.
- I have the right: To take pride in what I am accomplishing and to applaud the courage it sometimes takes to meet the needs of my loved one.
- I have the right: To protect my individuality and my right to make a life for myself that will sustain me when my loved one no longer needs my full-time help.
- I have the right: To expect and demand that as new strides are made in finding resources to aid physically and mentally impaired persons in our country, similar strides will be made toward aiding and supporting caregivers.

First appeared in Jo Horne's book Caregiving: Helping an Aging Loved One

Health and Economic Impacts of Caregiving

- As the person with dementia's symptoms worsen, caregivers can experience increased emotional stress and depression; new or exacerbated health problems; and depleted income and finances due in part to disruptions in employment and paying for health care or other services for themselves and people living with dementia
- A meta-analysis reported that caregivers of people with dementia were significantly more likely to experience depression and anxiety than non caregivers.
- Dementia caregivers also indicate more depressive symptoms than non-dementia caregivers. Approximately 30% to 40% of family caregivers of people with dementia report depression, compared with 5% to 17% of non-caregivers of similar ages.
- • The prevalence of depression is higher among dementia caregivers (30% to 40%) than other caregivers, such as those who provide help to individuals with schizophrenia (20%) or stroke (19%)
- The chronic stress of caregiving may be associated with an increased incidence of hypertension

OREGON - Percentage of caregivers reporting:

- Depression – 19.9%
- One chronic condition – 53.5%
- Frequent poor physical health – 16.7%

Healthcare Utilization by Caregivers

- Increased depressive symptoms among caregivers over time are linked to more frequent doctor visits, increased outpatient tests and procedures, and greater use of over-the-counter and prescription medications

Race/Ethnic Impacts on Caregivers

- Among non-White caregivers, half or more say they have faced discrimination when navigating health care settings for their care recipient, with the top concern being that providers or staff do not listen to what they are saying because of their race, color or ethnicity. This concern was especially high among Black caregivers (42%), followed by Native American (31%), Asian American (30%) and Hispanic (28%) caregivers. Fewer than 1 in 5 White caregivers (17%) expressed this view.
- Two in 5 caregivers (41%) who provide unpaid care to a Black person say that race makes it harder for them to get excellent health care. Nearly 1 in 3 caregivers of Hispanic people (32%) say the same.

Interventions for Caregiver support

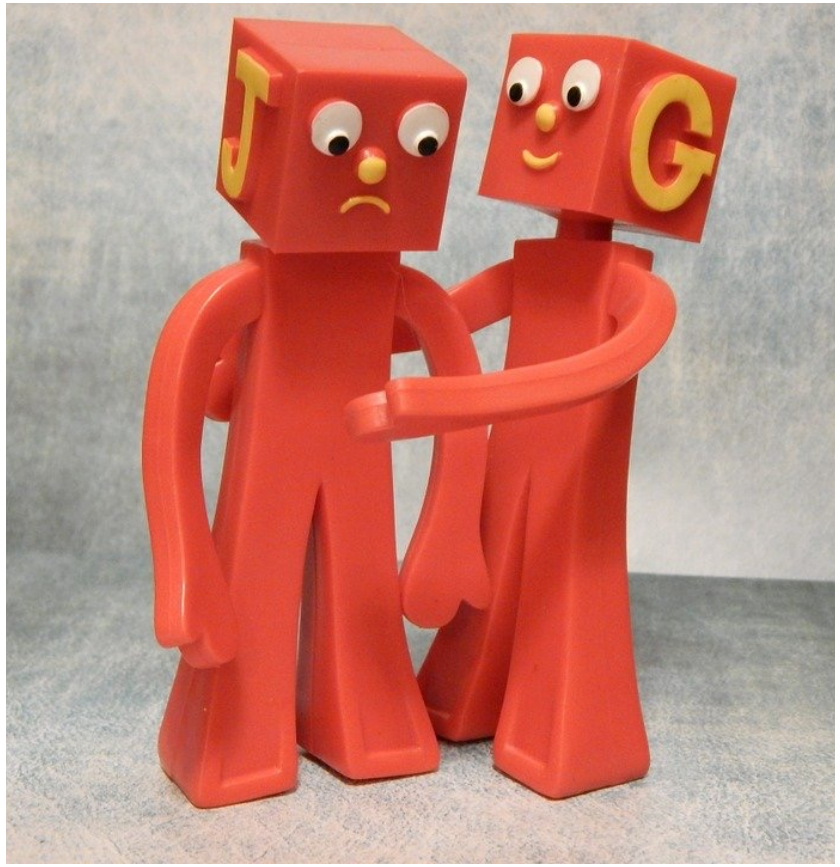
Case management - Provides assessment, information, planning, referral, care coordination and/or advocacy for family caregivers.

Psychoeducational approaches Include structured programs that provide information about the disease, resources and services, and about how to expand skills to effectively respond to symptoms of the disease (for example, cognitive impairment, behavioral symptoms and care-related needs). Include lectures, discussions and written materials and are led by professionals with specialized training.

Counseling Aims to resolve pre-existing personal problems that complicate caregiving to reduce conflicts between caregivers and care recipients and/or improve family functioning

Interventions for Caregivers

- Respite Provides planned, temporary relief for the caregiver through the provision of substitute care; examples include adult day services and in-home or institutional respite care for a certain number of weekly hours.
- Support groups Are less structured than psychoeducational or psychotherapeutic interventions. Support groups provide caregivers the opportunity to share personal feelings and concerns to overcome feelings of isolation.



Defining Elder Abuse

- Elder abuse includes physical, sexual, psychological, verbal abuse as well as neglect, abandonment and or financial exploitation of an older person by another person or entity.
- It can occur in any setting – at home or in a facility.
- Occurs in a relationship where there is an expectation of trust or when the person is targeted due to age or disability.
- Multiple forms of elder abuse may occur at the same time.

You are a frontline defender against elder abuse…

https://www.justice.gov/elderjustice

Elder Mistreatment (EM) and the ER

- EM is still missed in the ER
- In 2017, in a nationally representative sample, only about .01% of older adults presenting to U.S ER's formally received an EM diagnosis, which is more than 100 times less than the estimated prevalence of EM in U.S ER's (Evans et al.2017)
- Further, the use of a single question during triage such as "Are you safe at home?" has proven inadequate to identify EM (Stevens et al., 2018)

Detecting Elder Abuse in Primary Care Settings

- Despite multiple encounters (average Medicare beneficiary encountered healthcare system 17 days/year) and mandatory reporting statues, healthcare providers made only 11.1% of abuse reports with physicians accounting for 1 percent.
- A study of healthcare workers in 2012 including physicians identified five major categories why they failed to detect or report:
- 1.Professional orientation,2. assessment,3. interpretation,4. systems and 5.knowledge & education.

Elder Abuse increases mortality

- Elder abuse and neglect significantly shorten lives, even controlling for all other factors. Incidents of mistreatment that many would perceive as minor can have a debilitating impact on the older victim.
- A single episode of victimization can “tip over” an otherwise productive, self-sufficient older person's life. In other words, because older victims usually have fewer support systems and reserves—physical, psychological, and economic—the impact of abuse and neglect is magnified, and a single incident of mistreatment is more likely to trigger a downward spiral leading to loss of independence, serious complicating illness, and even death.

1998 Aug 5;280(5):428-32. /JAMA

Why is Dementia a Risk Factor Elder Abuse?

Vulnerable to abuse due to:

- Memory impairment
- Communication difficulties
- Compromised judgement
- As dementia progresses so does the risk of all types of abuse

RISK FACTORS

- Low social support
- Functional impairment
- Poor physical health
- Women more likely to be abused than men
- Lower income or poverty
- Living with large number of household members other than spouse
- Dementia

Victims are often:

- Frail
- Physically and or cognitively impaired
- Dependent on others
- Isolated
- Unable to report

What you can do

- Listen to older adults and others who may tell you about suspicions of abuse
- Do not discount an older adult's claim simply because of a cognitive impairment
- Look for elder abuse indicators and behavior changes
- Ask questions even if you do not suspect abuse to encourage disclosures

OREGON DATA 2017

- APS **conducted 16,793 investigations** to determine whether abuse or self-neglect had occurred.
- • These investigations encompassed **18,855 distinct allegations**, some of which involved multiple victims. Of those allegations,
- ➢ **13,138 or 70% were community allegations**
- ➢ 5,717 or 30% were facility allegations.

Add https://www.oregon.gov/DHS/SENIORS-DISABILITIES/ADULT-ABUSE/Documents/2019-0301-aps-databook.pdfa footer

COMMUNITY ALLEGATIONS 2017

- Of the community allegations, meaning the alleged victims live in a variety of community settings and the alleged perpetrator is not an employee or agent of a licensed residential facility, abuse or self-neglect was determined to have occurred in 3,672 cases (a 28% substantiation rate). Of those:
- ➢ 1168 or 32% were for financial exploitation
- ➢ 957 or 26% were for verbal abuse
- ➢ **560 or 15% were for self-neglect**
- ➢ 538 or 15% were for physical abuse
- ➢ **342 or 9% were for neglect**
- ➢ **82 or 2% were for abandonment, restraint, and seclusion**
- ➢ 25 or 1% were for sexual abuse

Addhttps://www.oregon.gov/DHS/SENIORS-DISABILITIES/ADULT-ABUSE/Documents/2019-0301-aps-databook.pdf a footer

GOALS for ELDER ABUSE AWARENESS DAY

ELDER ABUSE MUST BECOME A CULTURAL TABOO

ELDER ABUSE IS A VIOLATION OF HUMAN RIGHTS!

ZERO TOLERENCE OF ELDER ABSUE

Community Resourses

Resources

- **Always start with the ADRC**. Visit the website: www.adrcoforegon.org or call the toll-free statewide number at 1-855-ORE-ADRC. The good thing about calling the ADRC is that the trained information and referral specialists may be able to offer additional resources to a person/family that they didn't know existed. For instance, they may call about respite and learn they are eligible for home delivered meals. The ADRC is the "one stop shop" or "no wrong door" entry into our system.
- Adult Day Services - Adult day centers provide services to people who are disabled and/or confused or have memory loss. Participants socialize, eat nutritious meals and sometimes receive health services. They return home each night. https://www.adrcoforegon.org/consumersite/explore/in_your_community/adult_day_services.php

Resources

- The ADRC offers **person-centered options counseling.** A trained options counselor will meet with consumers/families and help them plan for the future on their own terms. They offer options based on what is important to the person/family. It doesn't cost a thing and it is open to people of any income. It is a GREAT planning service!
- https://www.oregon.gov/dhs/SENIORS-DISABILITIES/SUA/Documents/FCHandbook%20English.pdf
- Oregon Project Independence (OPI)

Oregon Project Independence

Could you be eligible for this program?

- If you are 60 years or older, and individuals of any age with Alzheimer's disease or a related disorder.
- Live in Oregon
- If you are 19 through 59 years old, have physical disabilities and live in one of these specific counties: Benton, Clatsop, Gilliam, Jackson, Josephine, Lane, Linn, Lincoln, Marion, Hood River, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Wasco, Washington, Wheeler and Yamhill.
- Do not receive Medicaid (financial or medical help) except for Food Stamps or assistance with Medicare premiums.
- **Is there a cost for the services?**
- Yes. All people who are able to use this program have to pay for some of the cost of the services. There is a sliding scale fee. The cost to you is based on your monthly household income minus your household's monthly medical costs.

Resources

- **Virtual Support Groups – Alzheimer's Association** We offer peer-or professionally led groups for caregivers, individuals living with Alzheimer's and others dealing with the disease. All support groups are facilitated by trained individuals. Many locations offer specialized groups for children, individuals with younger-onset and early-stage Alzheimer's, adult caregivers and others with specific needs. However, in-person meetings are paused due to the COVID-19 pandemic. All support groups will be hosted via phone or video conference for the time being.
- **Oregon Care Partners** is a free, high-quality education resource. We help family and professional caregivers build the knowledge and skills needed to improve the quality of life of older adults and people living with Alzheimer's in Oregon. https://oregoncarepartners.com/

Resources

- Older Adult Behavioral Health Initiative – 26 older adult BH specialist through out Oregon - https://oregonbhi.org/. Reach out to your specialist to consult on a complex case, request dementia specific training for your staff or agency or explore resources.
- Adult Protective Services – reporting abuse of **any** vulnerable individual, including children. CALL THE SAFE LINE -
- **SAFE line: Call 1-855-503-SAFE (7233) AND** APS.TechAssistance@dhsoha.state.or.us - send email for assistance on complex cases.

MEDICARE ANNUAL WELLNESS VISIT

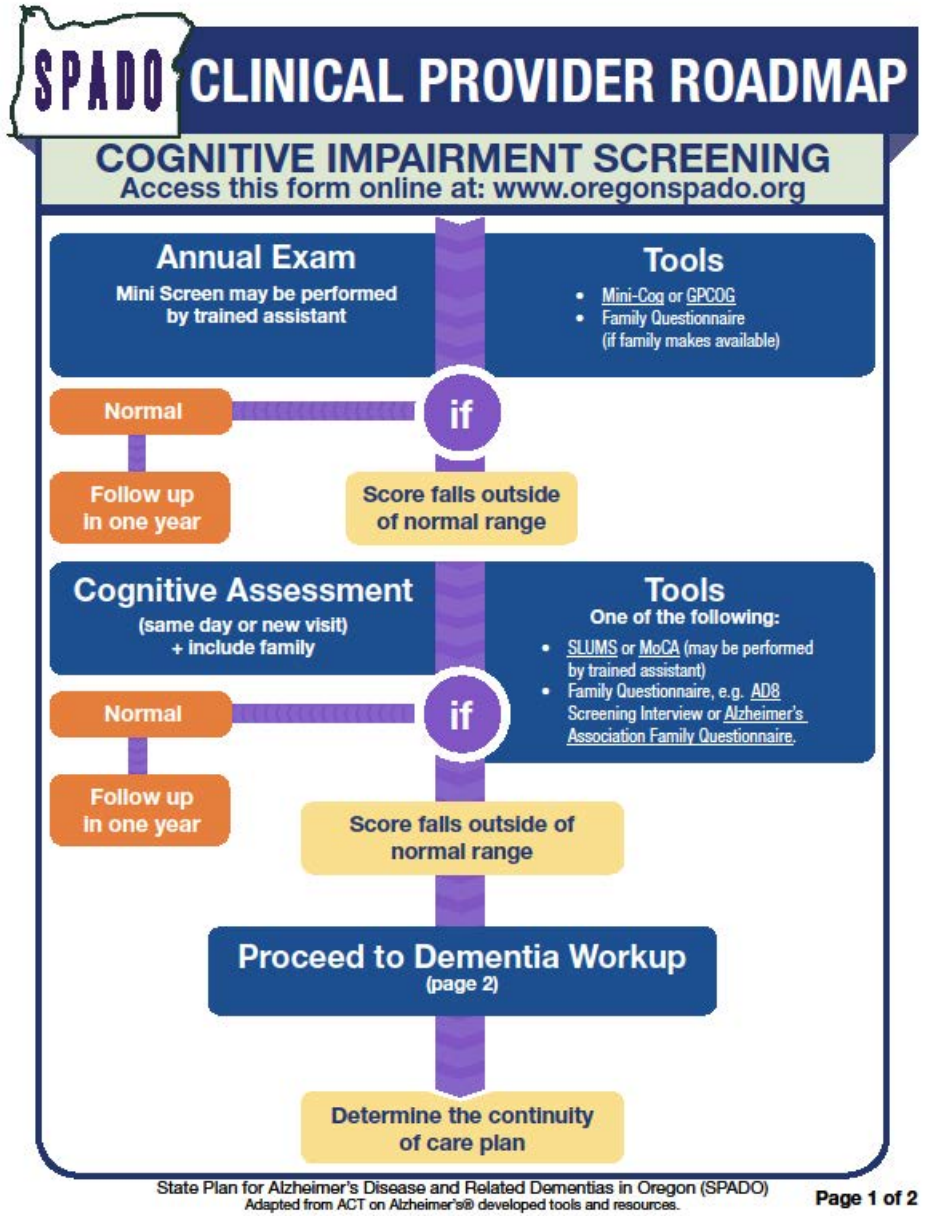
Under the Affordable Care Act, Medicare pays for an Annual Wellness Visit, which includes the creation of a personalized prevention plan and detection of possible cognitive impairment. This benefit began on January 1, 2011.

Detection of cognitive impairment is included in the Annual Wellness

Medicare will pay for an Annual Wellness Visit once every 12 months.

HCPCS CODES G0438 OR G0439

https://www.alz.org/media/Documents/factsheet-medicare-annual-wellness-visit-2017.pdf



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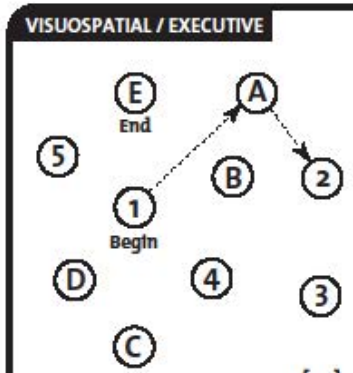
SCREENING INSTRUMENTS

- SLUMS (St. Louis University Mental Status)
- Montreal Cognitive Assessment (MoCA)
- Clock Drawing
- Mini-Cog
- Trails B

MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME :
Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE



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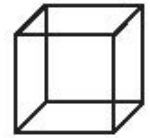


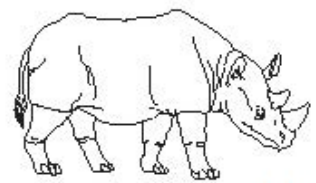
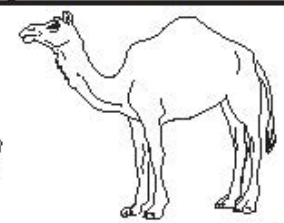
[ ] [ ]

Draw CLOCK (Ten past eleven) (3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS __/5

NAMING

[ ] [ ] [ ]

__/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4

Subject has to repeat them in the backward order [ ] 7 4 2

__/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

__/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

__/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ]

__/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] ____ (N ≥ 11 words)

__/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

__/2

DELAYED RECALL

	Has to recall words WITH NO CUE	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
		[ ]	[ ]	[ ]	[ ]	[ ]	
Optional	Category cue						
	Multiple choice cue						

__/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

__/6

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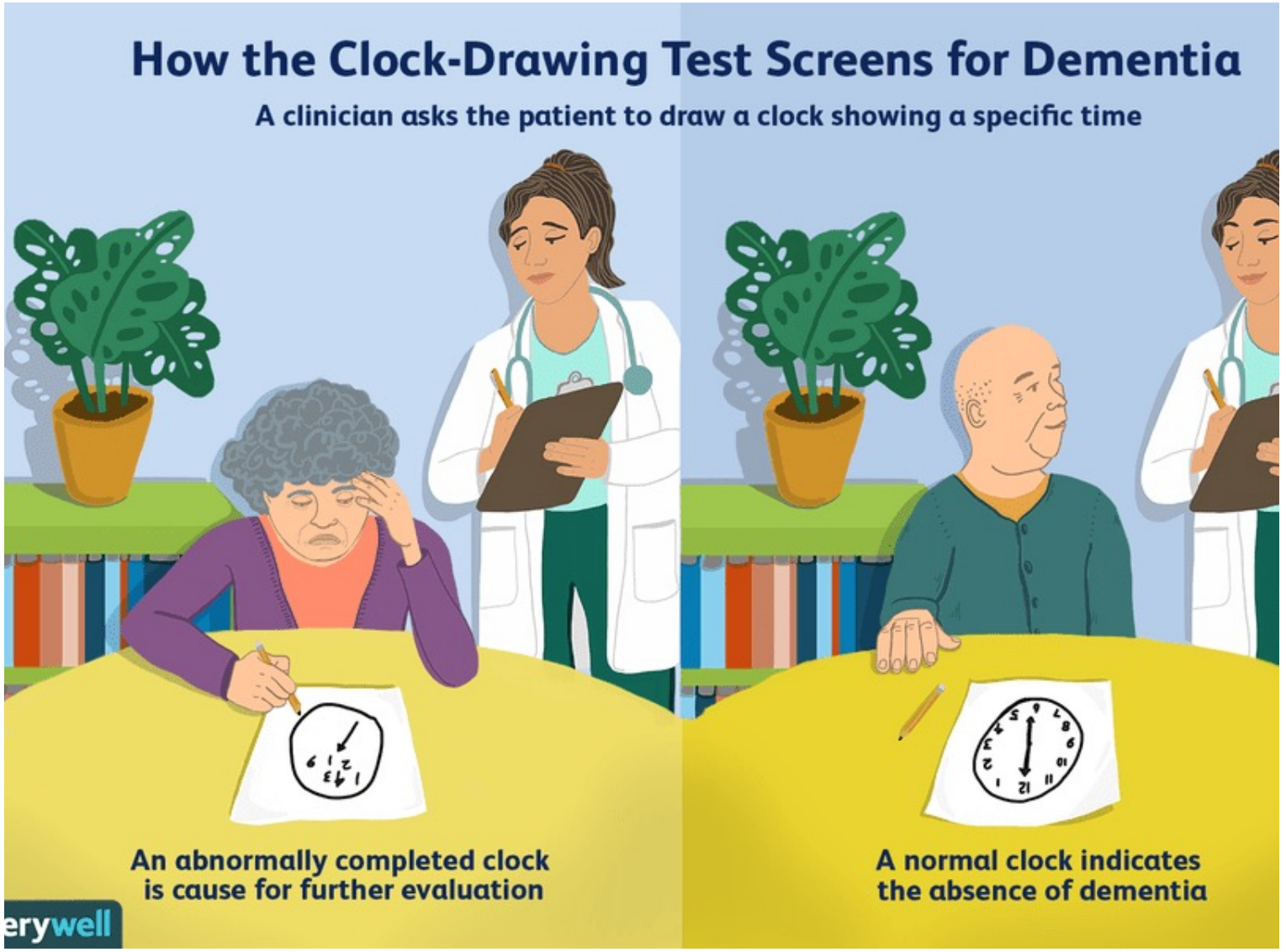
www.mocatest.org

Normal ≥ 26 / 30

TOTAL __/30

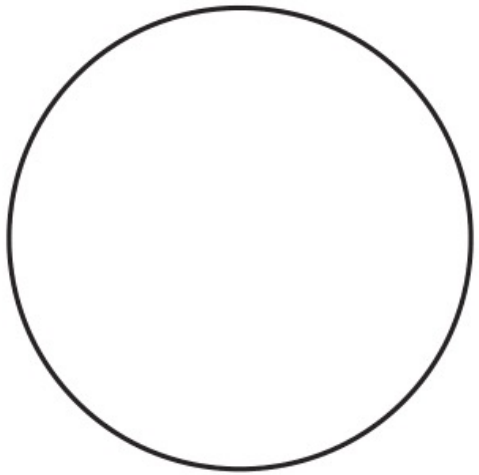
Add 1 point if ≤ 12 yr edu

The Clock Drawing Test



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.

The Verbal Fluency Test (VFT)

- The test consists of giving the person 60 seconds to verbally list as many things as possible in a category.

Semantic/Category Subtest

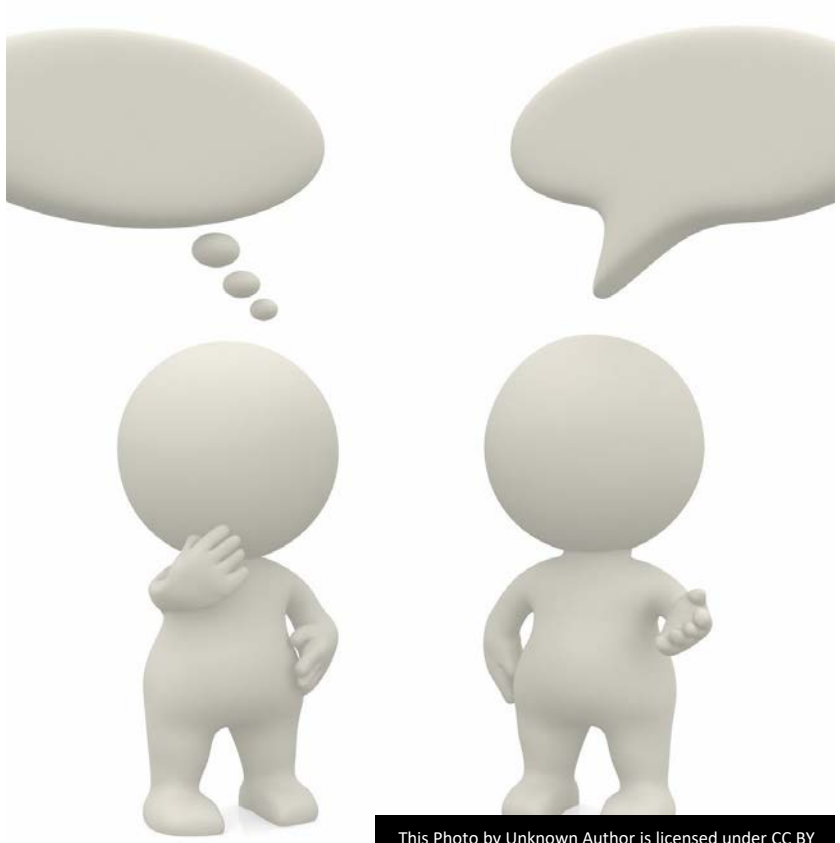
- The person is asked to list all of the animals he can think of in the next 60 seconds (fruits, vegetables)

Phonetic/Letter Subtest

- In the phonetic subtest, a letter is chosen by the test administrator and the person is asked to name all of the words that begin with that particular letter. The most common letters chosen are F, A, and S.

Scoring

- To score the VFT, count up the total number of animals or words that the individual is able to produce. A score of under 17 indicates concern, although some practitioners use 14 as a cutoff.



Resources

- https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf - 2021 ALZHEIMER'S DISEASE FACTS AND FIGURES SPECIAL REPORT Race, Ethnicity and Alzheimer's in America
- https://academic.oup.com/gerontologist/article/58/suppl_1/S1/4816759
- https://www.alz.org/media/Documents/oregon-alzheimers-facts-figures-2021.pdf

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