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Psychiatry and Addictions Case Conference
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# WORKING WITH OLDER ADULTS WITH COGNITIVE CONCERNS


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Integrated Care Training Program
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# SPEAKER DISCLOSURES

✓ No conflicts of interest

# PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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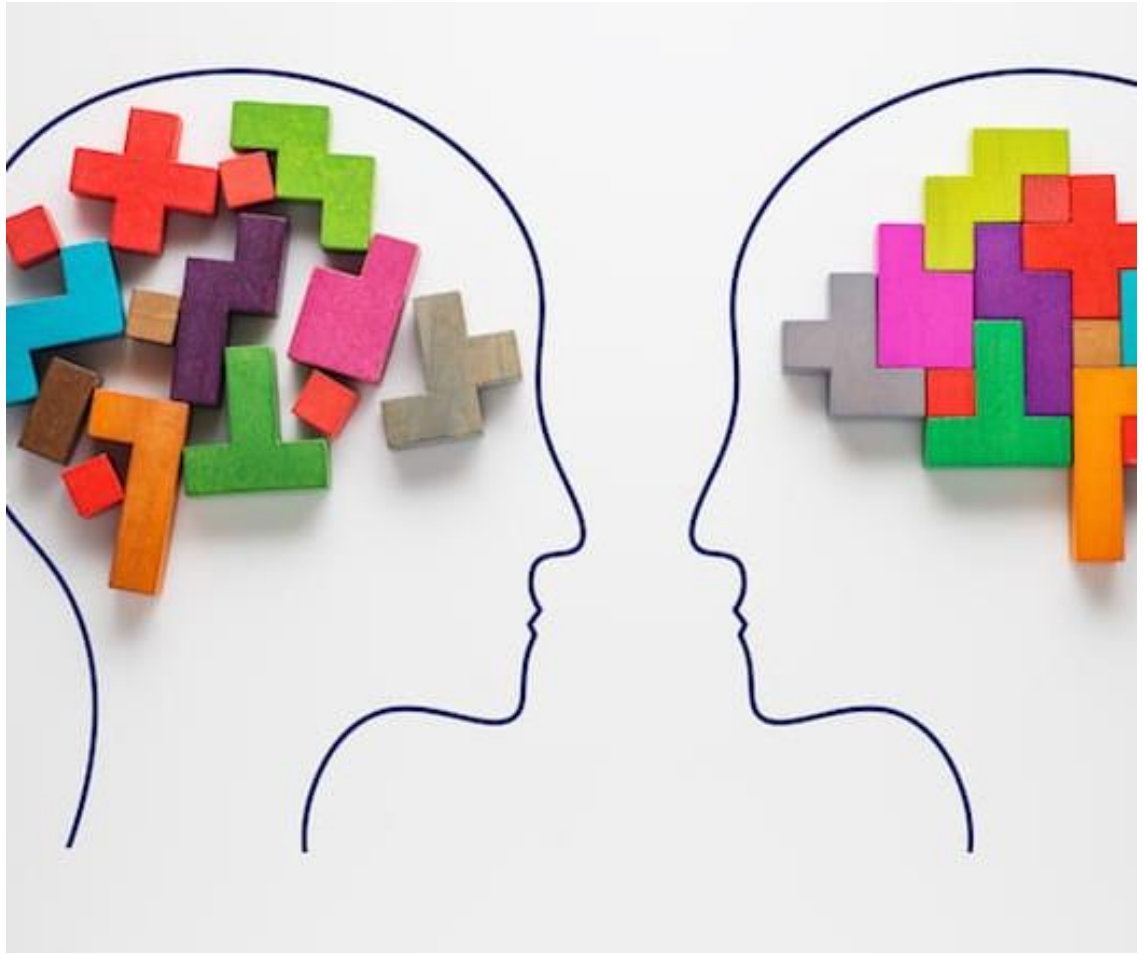
# OBJECTIVES



1. Explain the difference between typical cognitive aging versus dementia.
2. Summarize approaches to promote healthy cognitive aging.
3. Identify common caregiving and behavioral challenges associated with cognitive concerns.
4. Recommend psychoeducation and support resources for families and caregivers.

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# ACCORDING TO THE UNITED NATIONS (UN), BY 2050, 1 IN 6 PERSONS WILL BE 65+ YEARS OF AGE.

(United Nations Department of Economic and Social Affairs. World population ageing 2019.)

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# WHAT IS "SUCCESSFUL AGING"?

## Low probability of disease

- Subjective well-being (low level of perceived stress)

## High cognitive and physical function

- Flourishing (meaning of life, close social relationships)

## Active engagement with life

- Post-traumatic growth
- Sustained remission or recovery for individuals with severe mental illness with functional independence

(Livingston, Huntley, Sommerlad, et al., 2020; Reynolds, Jeste, Sachdev, & Blazer, 2022, p. 339; Rowe & Kahn, 1997)

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# COGNITIVE CHANGES IN AGING - FLUID INTELLIGENCE

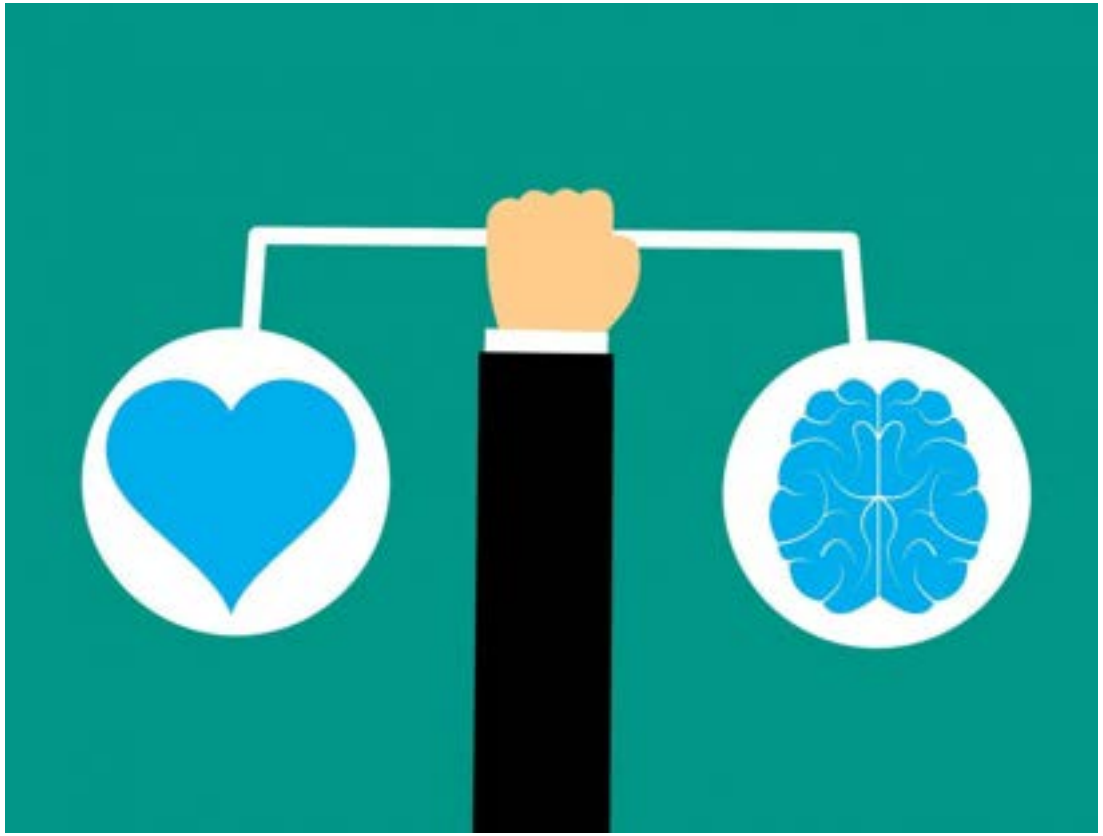
- **Processing Speed**
  - Speed of cognitive activities as well as motor responses
  - ↓ with age
- **Attention**
  - "Ability to concentrate and focus on specific stimuli" (p. 3)
  - Immediate memory, selective attention, divided attention, working memory
    - Immediate memory stays relatively constant with age
    - Complex attention task abilities ↓ with age



(Harada, Love, & Triebel, 2013, p. 3)

# WHAT CONTRIBUTES TO OR EXACERBATES COGNITIVE AGING?

- Genetic predisposition
- Traumatic brain injury
- Adverse environmental childhood experiences
- Poor educational and cognitive enrichment experiences
- Chronic health conditions (e.g., diabetes, vascular conditions, chronic lung and liver conditions, COPD, vision and hearing loss, sleep disorders)
- Mental illness (e.g., major depression, bipolar disorder, schizophrenia, substance use, anxiety disorders)



(Morrison & Baxter, 2012; Teissier, Boulanger & Deramecourt, 2020; US Institute of Medicine, 2015)

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# DON’T FORGET NEUROPLASTICITY!

Physical, Cognitive,
Social activities

New synapses, dendrites, blood vessels, and neurons!

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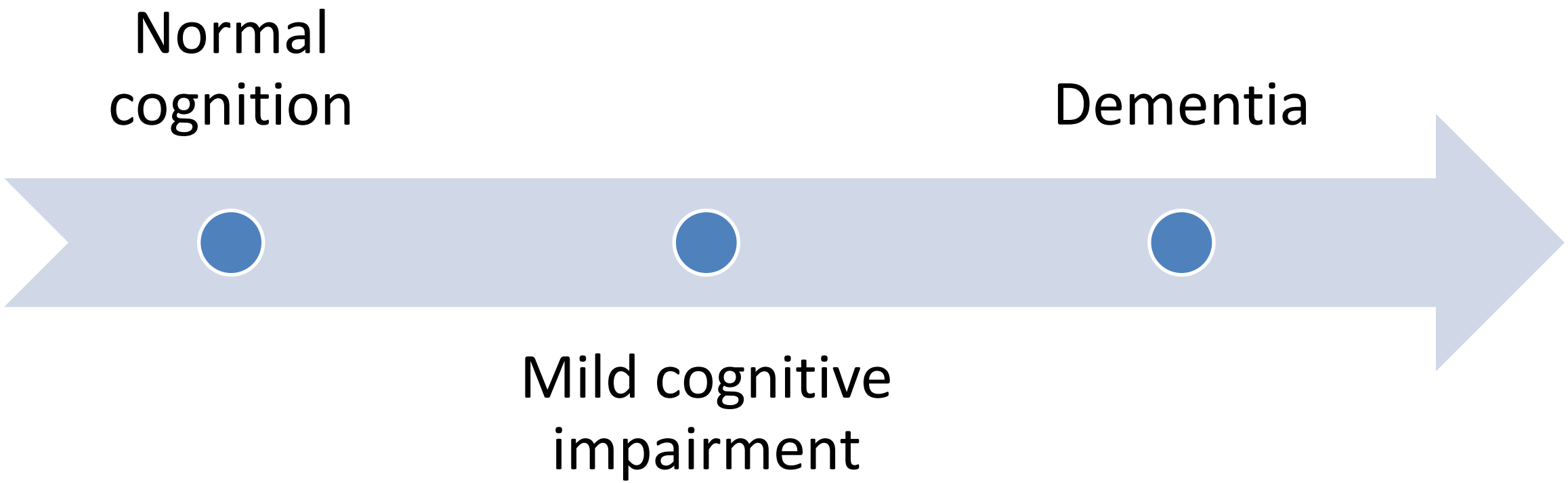
# COGNITIVE IMPAIRMENT ON A CONTINUUM

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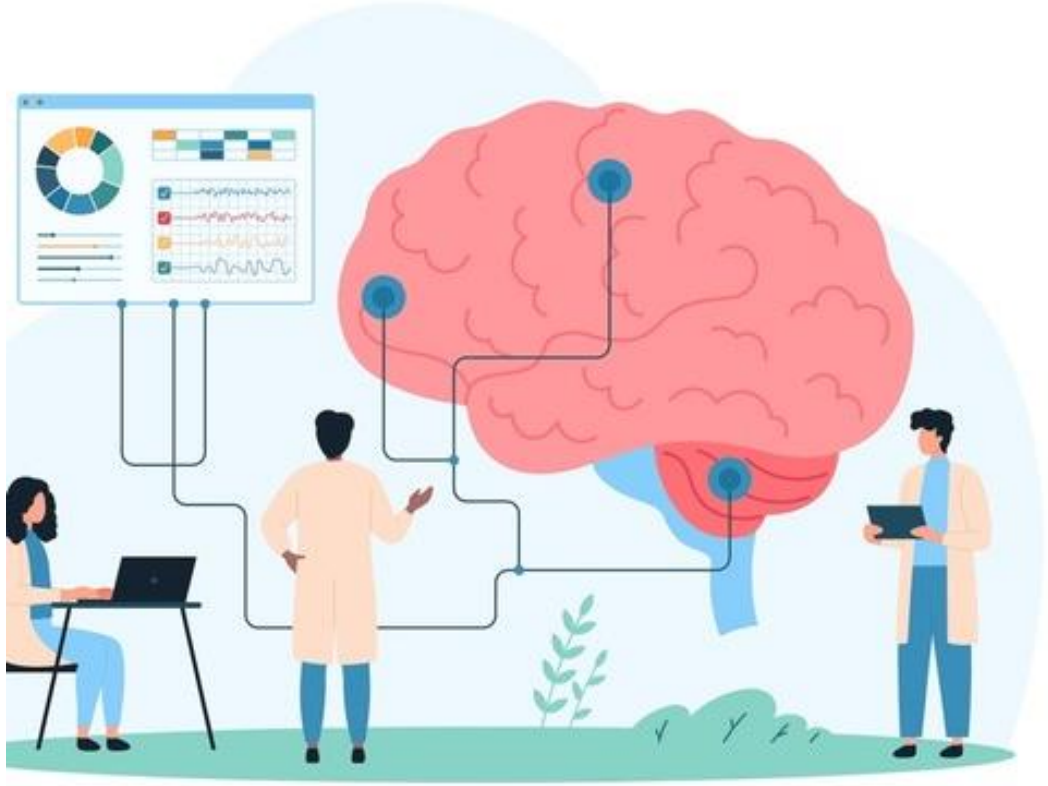
# 10 WARNING SIGNS OF DEMENTIA

- Memory loss that disrupts daily life.
- Challenges in planning or solving problems.
- Difficulty completing tasks at home, at work or at leisure.
- Confusion with time or place.
- Trouble understanding visual images and spatial relationships.
- New problems with words in speaking or in writing.
- Misplacing things and losing the ability to retrace steps.
- Decreased or poor judgment.
- Withdrawal from work or social activities.
- Changes in mood or personality.

(https://www.alz.org/alzheimers-dementia/10_signs)

# DEMENTIA IN THE CLINIC: YES YOU CAN!



- Make the diagnosis
- Provide education, support, and treatment options
- Ensure that treatment of other medical conditions is appropriate
- Provide primary palliative care
- Assist with advance care planning

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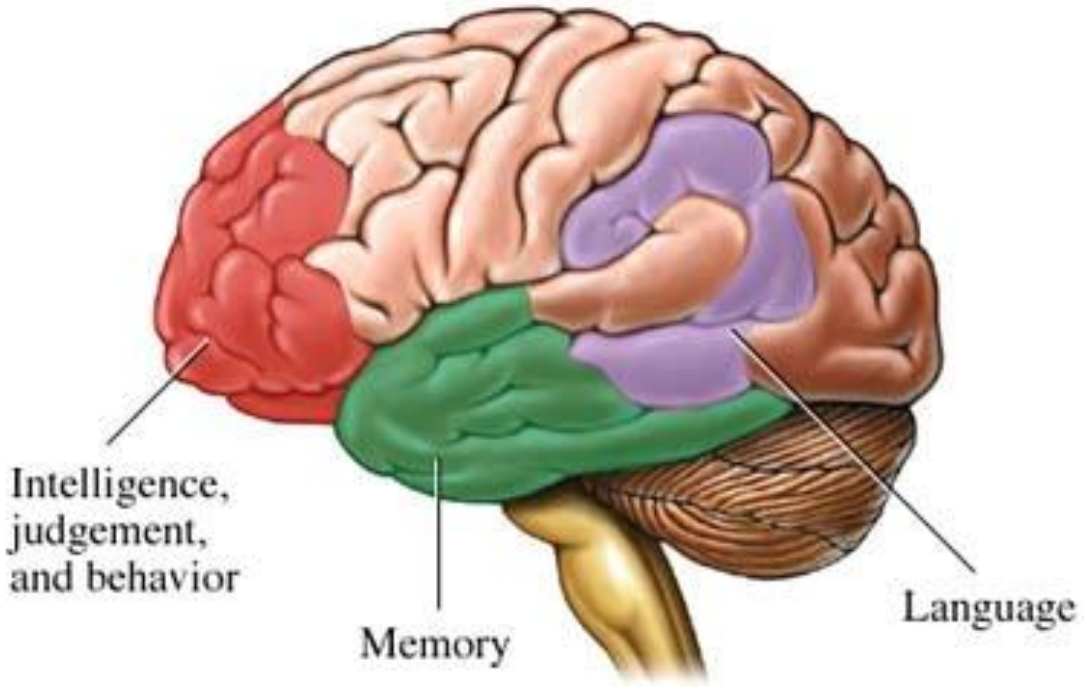
# JUST ANOTHER DAY IN PRIMARY CARE…

- You are meeting with an 80yo F patient and her daughter. The patient was recently diagnosed with dementia. Her daughter starts the visit by saying, ”I know my mom is getting more forgetful, but she can still remember so many things – like detailed information about past travel and she can tell me all about her childhood and young adulthood. I think she’s just not trying hard enough to remember recent things. I keep telling her she needs to try harder. And I don’t think she has dementia. It’s not like she has Alzheimer’s.”

- The patient’s recent MoCA was 19/30, she is needing help remembering to take her medications, and is getting lost while driving.

# DIAGNOSIS IN THE OFFICE

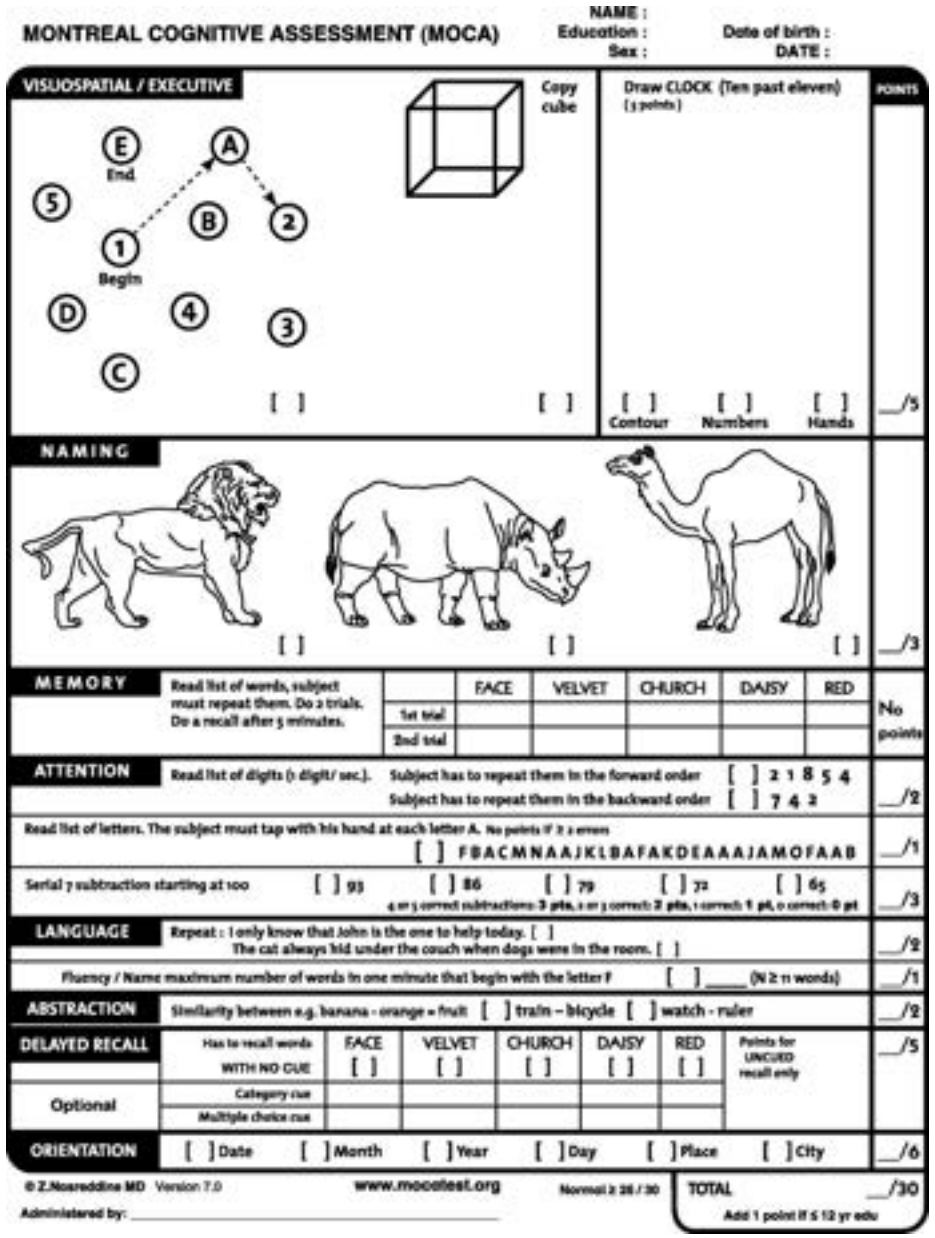



- History of decline
- Functional assessment
- Cognitive testing
- Ruling out other etiologies
- Biomarkers?

- *Diagnosis is often delayed or not given.*

# COGNITIVE TESTING

- Office testing
  - Mini-cog
  - GP-COG
  - MoCA (www.mocatest.org)
  - SLUMS
  - RUDAS
    - Score sheet
- Informant Questionnaires
  - Informant Questionnaire of Cognitive Decline in the Elderly (IQCODE)
  - IADLs
- Neuropsychological testing


MONTREAL COGNITIVE ASSESSMENT (MOCA)

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

VISUOSPATIAL / EXECUTIVE — Copy cube — Draw CLOCK (Ten past eleven) (3 points) — POINTS — /5

Contour [ ] Numbers [ ] Hands [ ]

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. [ ] 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 — /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 — /5

Optional — Category cue — Multiple choice cue

ORIENTATION — [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City — /6

© Z.Nasreddine MD Version 7.0 — www.mocatest.org — Normal ≥ 26 / 30 — TOTAL /30 — Add 1 point if ≤ 12 yr edu

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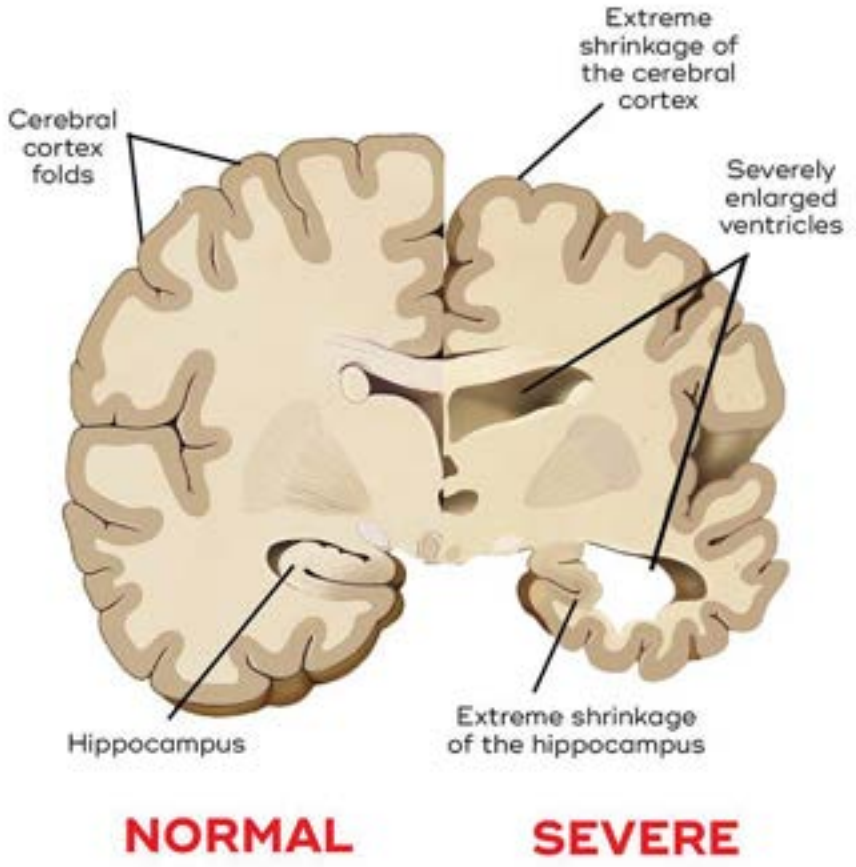
# DEMENTIA IS A PROGRESSIVE, DEGENERATIVE, TERMINAL NEUROLOGIC DISEASE.

- In the early stages, memory is impaired.
- Eventually, the entire nervous system is affected, and the patient loses the ability to speak, walk, control the bladder and bowels, and swallow food.
- Ultimately, dementia is a fatal illness.

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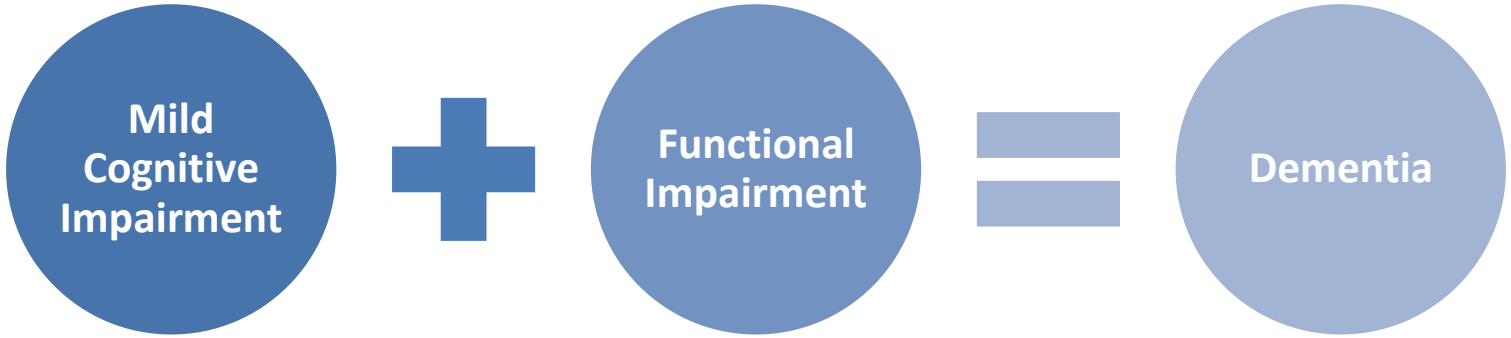
# MILD COGNITIVE IMPAIRMENT AND DEMENTIA

**Mild Cognitive Impairment** (MCI) "is a slight but measurable decline in cognitive abilities that includes memory and thinking"

**Functional Impairment** - changes in ability to navigate day to day life independently (e.g., taking medication, managing finances, cleaning, meal prep, laundry)

"**Dementia** is a general term referring to a loss of cognitive function—remembering, thinking, and reasoning—*severe enough to interfere with everyday life*."




(Dementia Road Map, 2019, p. 8)

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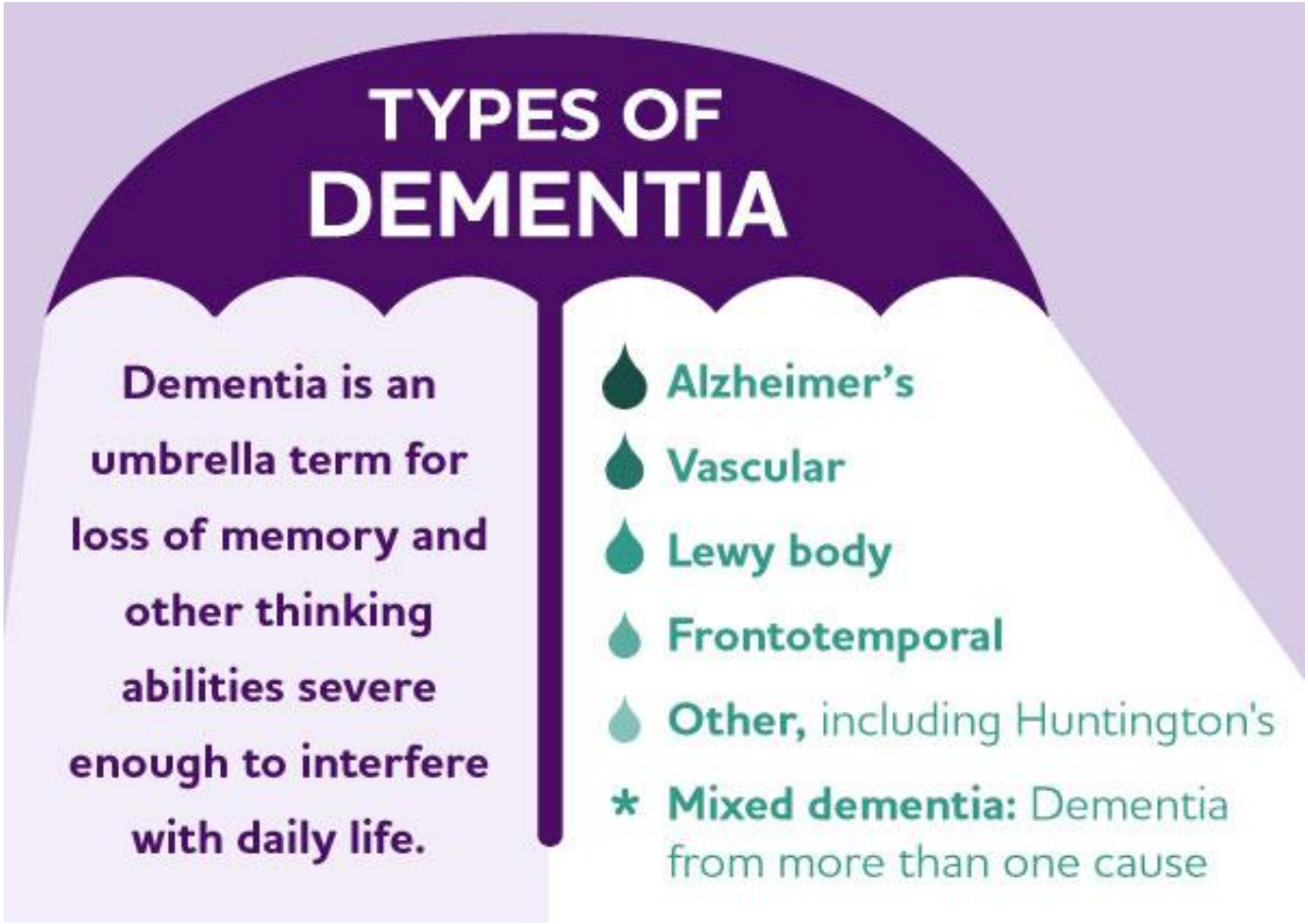


(https://www.alz.org/alzheimers-dementia/what-is-dementia)

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# SAFETY CONCERNS



- Driving
- Medication Management
- Financial decisions
- Wandering
- Cooking
- Supervision at home
- Susceptibility to fraud

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# COMMON BEHAVIOR CHALLENGES BY STAGE

**Changes in Social and Task Behaviors by Dementia Stage**

| | Social Behaviors | Task Behaviors |
|---|---|---|
| **Early Dementia** | • Initiates and responds to social greetings and interactions<br>• Carries on a conversation without much prompting<br>• Seeks out unfamiliar activities when comfortable but familiar activities when distressed<br>• Can use verbal and visual cues<br>• Can select among options | • May lack initiation of a task<br>• Relies on routines<br>• Can easily choose among options<br>• May discontinue challenging tasks<br>• Can perform ADLS<br>• Has difficulty with some IADLs |
| **Middle Dementia** | • Can initiate social greetings<br>• Can respond to social<br>• Greetings<br>• Has very short conversational exchanges<br>• Can make simple choices | • Can start or repeat task with cueing<br>• Relies more on visual cues<br>• Responds to brief verbal cues<br>• Easily forgets the task at hand<br>• May forget activities already complete |
| **Advanced Dementia** | • Minimal ability to converse<br>• Avoids or resists unpleasant stimulation through nonverbal means<br>• Unable to put together complete picture | • Focus on tactile cues, colors<br>• Stimulus bound<br>• Utilization bound<br>• Scattered attention<br>• May put non-food items in mouth |

*Adapted from Snow (2008) with permission.*

(STAR-VA, p. 16)

# WHAT ARE SOME OF THE CAREGIVING AND BEHAVIOR CHALLENGES FAMILIES AND PATIENTS EXPERIENCE?

# COMMON BEHAVIOR CHALLENGES

- Aggression and anger
- Anxiety and agitation
- Depression/apathy
- Hallucinations
- Memory loss and confusion
- Repetition
- Sleep issues and sundowning
- Suspicions and delusions
- Wandering

(https://www.alz.org/alzheimers-dementia/treatments/treatments-for-behavior)

# TREATMENT



"The treatment of neuropsychiatric symptoms remains a challenge. The current evidence suggests that the role of drug treatment is limited, and non-pharmacological strategies are first line, in particular some behavioral management techniques, especially those involving caregiver- and staff-oriented interventions."

– Reynolds, Jeste, Sachdev & Blazer, 2022, p. 342

# BEHAVIORS ARE COMMUNICATION

"People with dementia are trying to make sense of the world around them in the best way that they can."

"...each person...has a lifelong history of responding to other people and situations in certain ways, and the brain disease may exaggerate these patterns."

"...dementia lowers an individual's ability to tolerate stress and fatigue. Problem behaviors may reflect a [loved one's] frustration at being unable to communicate verbally something that is troubling him or her (e.g., physical pain or feeling frightened)."

(STAR-VA, p. 17)

# WHAT'S THE PROBLEM?

- A 75yo M presents with his spouse for follow-up regarding depression and memory changes.  His spouse reports that the patient keeps asking the same question over and over again, and she [spouse] is very frustrated.  The spouse reports she tells the patient that he already asked the question, which doesn't help.  Per spouse, the patient has been more irritable and easily upset when he used to be so easygoing.

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# TOOLS FOR UNDERSTANDING DIFFICULT BEHAVIORS

"To effectively understand a challenging dementia-related behavior, it is crucial to understand the circumstances surrounding the behavior."

**The ABC's of Behavior**

- The **A-activator** is what happens just before the behavior
- **B-behavior**
- The **C-consequence** is what occurs just after the behavior and can make the behavior better, continue, or worsen

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# ABC'S OF BEHAVIOR

## Activator

- Cause or a trigger of the behavior.
- Can be internal or external.

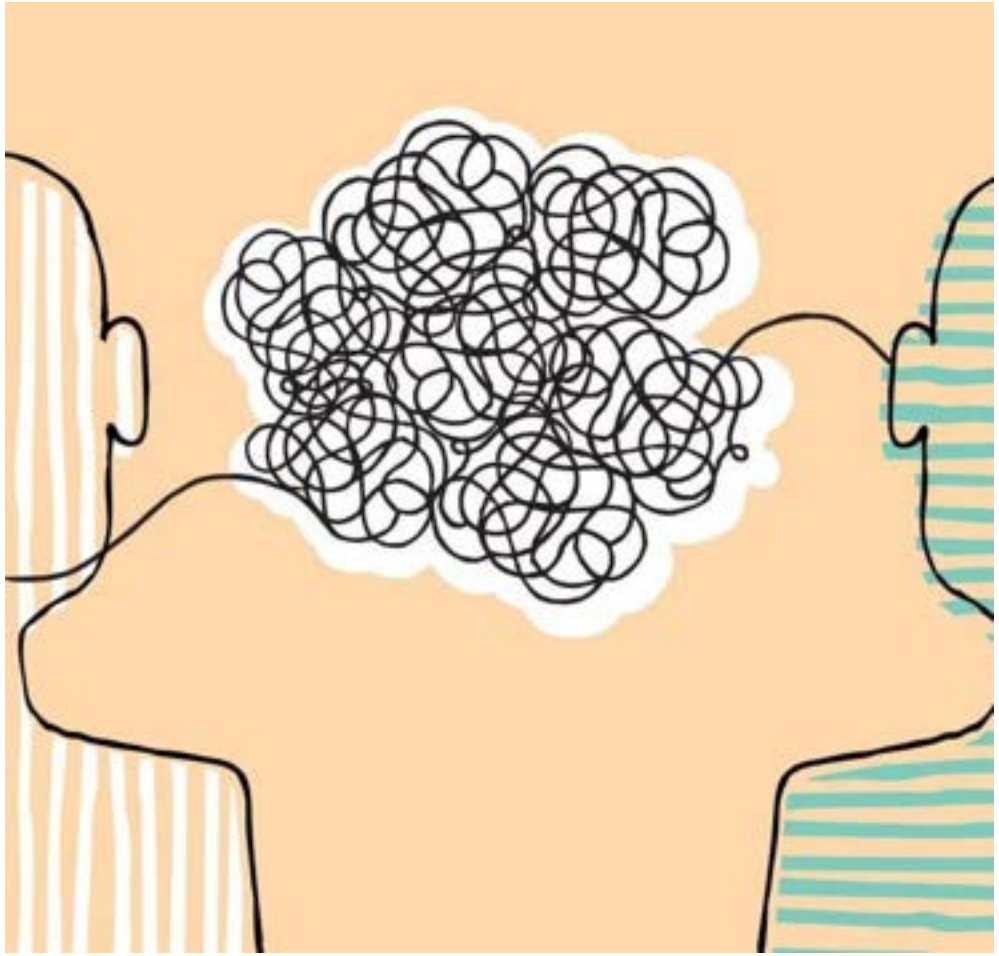
## Behavior

- Observable
- What was loved one doing?
- Who was present?
- Where was behavior happening?
- When was behavior happening?

## Consequence

- What follows a behavior.
- Consequences cause behaviors to get better, continue, or get worse.
- Consequences that worsen or maintain behavior should be eliminated. Consequences that improve behavior can be incorporated into behavior plan.

# COMMUNICATION TIPS



- Nonverbal behaviors can enhance communication.  These can include a kind gesture, a positive/pleasant tone of voice, a smiling face, and a relaxed body posture.
  - Be present
  - Avoid distractions
  - Position yourself to make eye contact
- The message we send to others is not always the message received. This is often especially the case with individuals with dementia.
- Communication can be a powerful activator of a loved one's behavior.
- When there is a problem, check the nonverbal messages being sent.
- Loved ones may become overwhelmed or confused when asked too many questions or given too many instructions.

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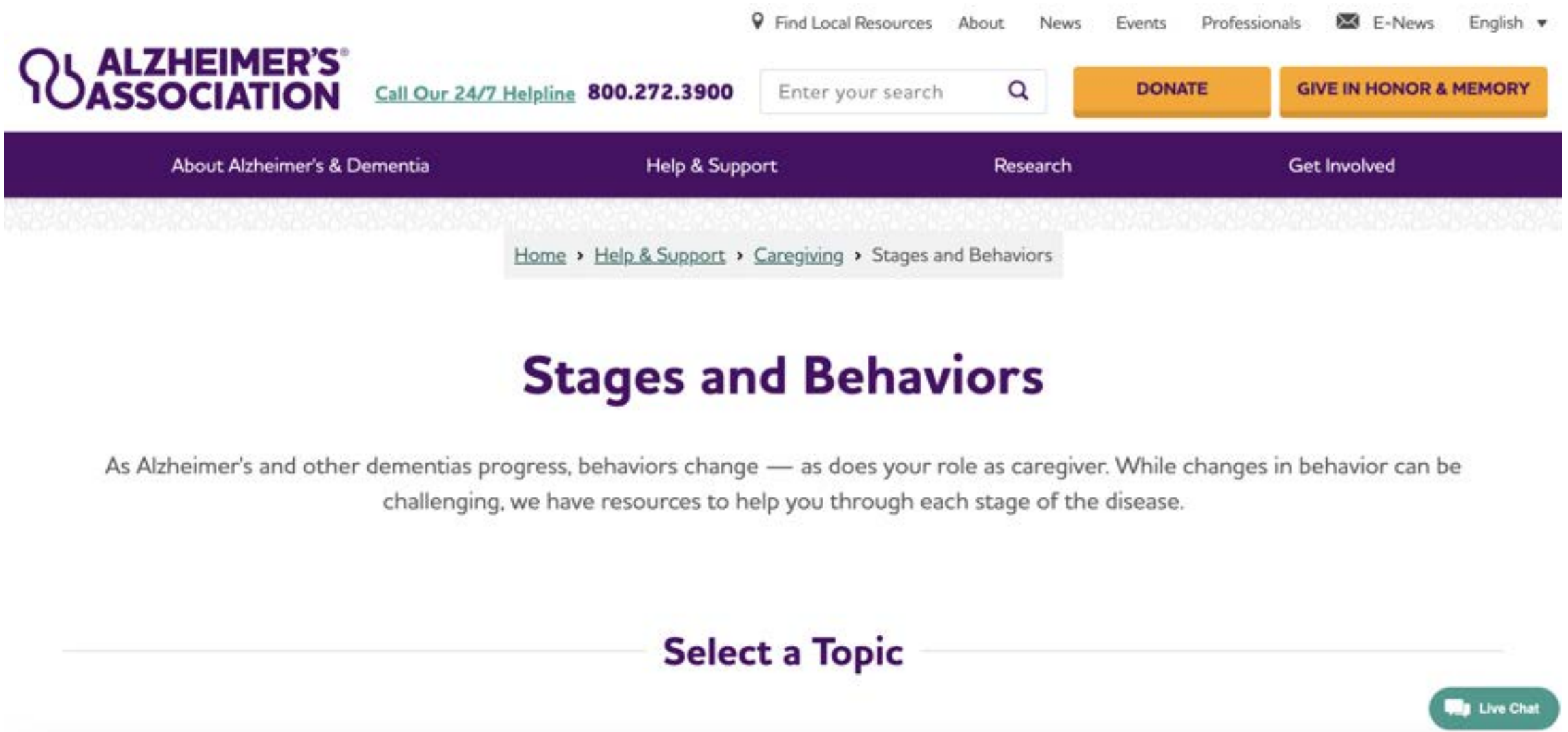
# TYPES OF ACTIVATORS OF CHALLENGING BEHAVIORS

| | |
|---|---|
| **Medical** | • Infection<br>• Pain or physical discomfort<br>• Medication side effects<br>• Incontinence or constipation<br>• Hunger or dehydration<br>• Lack of sleep or fatigue<br>• Sensory loss |
| **Psychological** | • Sadness (or reminders of a sad event)<br>• Loneliness<br>• Feeling scared or anxious<br>• Anger |

# TYPES OF ACTIVATORS OF CHALLENGING BEHAVIORS

| | |
|---|---|
| **Environmental** | • Too much noise, activity, clutter, and/or people<br>• Unfamiliar persons, places, and/or things<br>• Startling movements, noise, or touch<br>• Insufficient lighting<br>• Changes in schedules and routines<br>• Shift changes<br>• Being left alone for too long, boredom |
| **Interpersonal** | • Repeated questions or demands<br>• Caregiver impatience, tone of voice<br>• Inability to perform simple tasks (becoming frustrated)<br>• Being rushed<br>• Being touched or held in ways that are frightening or confining<br>• Verbal reasoning and logical explanations<br>• Activities perceived as insulting or child-like |

# ALZ ASSOCIATION - TREATMENTS FOR BEHAVIOR




(https://www.alz.org/help-support/caregiving/stages-behaviors)

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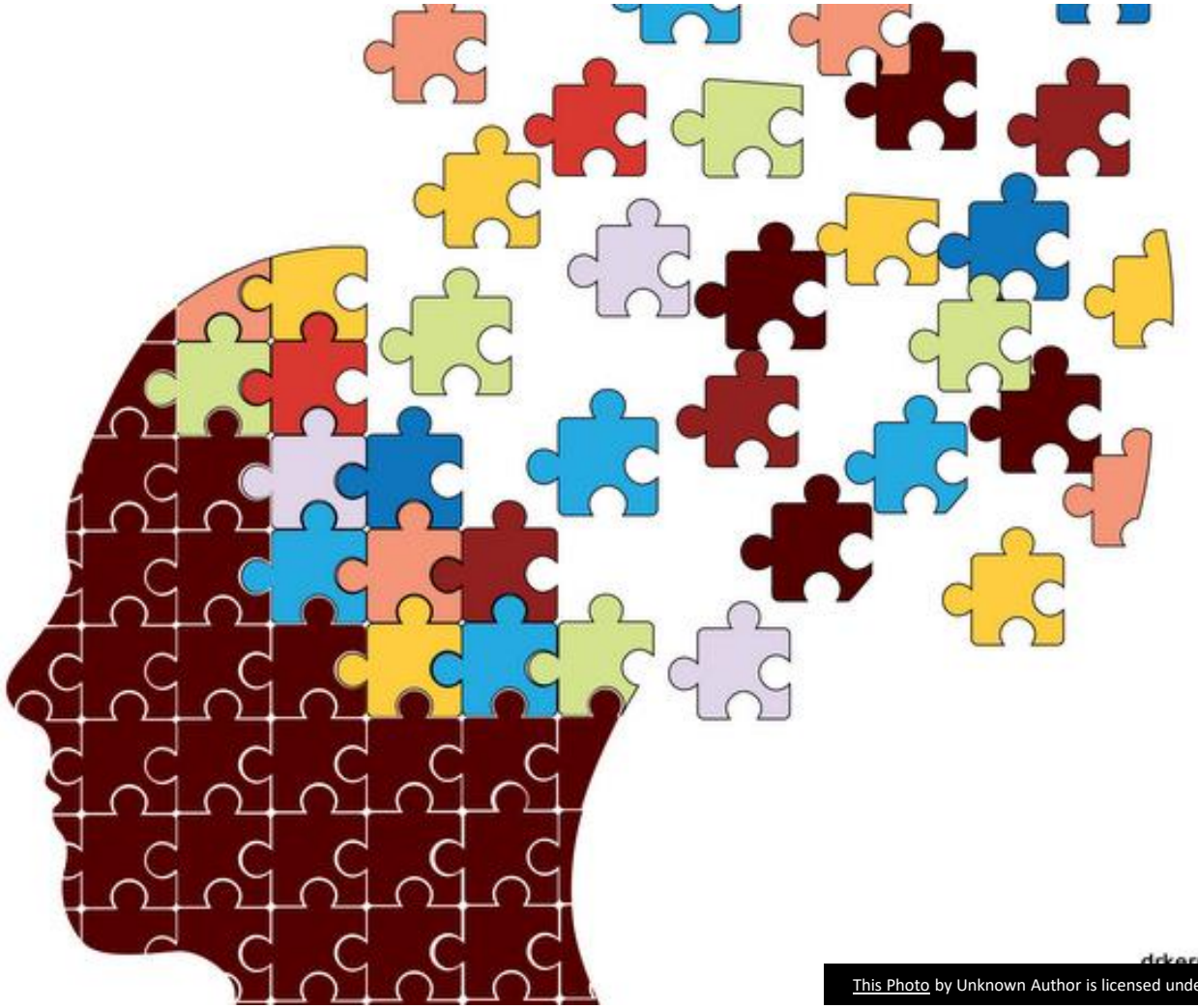
# BEHAVIORAL HEALTH SUPPORT





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**DEMENTIA ROADMAP**

## Action Steps Summary

- ❑ **Obtain a medical assessment** of memory loss/cognitive impairment and diagnosis for your loved one—this opens the door to necessary planning. This process should start with your health care practitioner, and may involve other specialists such as a Geriatrician, a Neurologist, and/or a Neuropsychologist
- ❑ **Contact the Alzheimer's Association** or Alzheimer Society of Washington (Whatcom County) for information and support.
- ❑ **Contact your area's Community Living Connections** (Area Agency on Aging/Family Caregiver Support Program).
- ❑ **Complete health care planning documents.** Your loved one should have:
  - A Health Care Directive (also called a "living will" or "advance directive" regarding treatment preferences); and
  - A Durable Power of Attorney for Health Care, appointing a health care "agent."
- ❑ **Complete a General Durable Power of Attorney document.** In this document, your loved one appoints an "agent" to assist with financial and related matters.
- ❑ **Complete an estate plan.** Your loved one's estate plan may include legal documents such as a will or a trust that direct the disposition of their estate upon death.
- ❑ **Consider Care Coordination** or Case Management Services: "Guides" for the journey, they can assist with each step.
- ❑ **Complete end-of-life planning** and document how your loved one wants to live at the end of their life, including medical care wanted or not wanted, comfort measures, and palliative and hospice care.
- ❑ **Discuss with loved one the issue of when to discontinue driving.** If needed, enlist help of healthcare provider, a professional driving evaluation, or call the Alzheimer's Association for more ideas.
- ❑ **Make sure your loved one either carries ID** or wears MedicAlert+Safe Return jewelry.
- ❑ **If help with financing care is needed,** contact your local Community Living Connections or Home and Community Services offices. Find these at ***www.waclc.org/connect***.
- ❑ **Have family meetings** along the way to discuss what's happening, and how to support the person with memory loss and care partner. Important topics of discussion include:
  - Encouraging a diagnosis; Discussing safety issues, such as driving and safe medication use;
  - Needing support with financial or legal planning;
  - Coordinating care at home;
  - Considering safe living situation and options;
  - Discussing ways to support the primary care partner/caregiver.
- ❑ **Request a home safety evaluation** with a Physical or Occupational Therapist to make the home safer and home care tasks easier.
- ❑ **Make and update a back-up plan** along the way to be used if something happens to you.
- ❑ **Discuss and seek palliative care** and hospice care.
- ❑ **Talk to health care professional** about establishing a Physician's Order for Life Sustaining Treatment (POLST) when appropriate.

# A TEAM BASED APPROACH TO DEMENTIA CARE

- Behavioral Health can assist with:
  - Gathering history of symptom progression
  - Cognitive screening
  - Gathering information from informants
  - Psychoeducation for families
  - Problem solving regarding challenging behaviors
  - Support in discussions regarding goals of care
  - Evidence based interventions for depression, anxiety, sleep IF cognitive abilities allow
  - Concerns regarding capacity/safety

# BEHAVIORAL HEALTH CONSULTS

- Warm Handoffs/shared visits
- Tools for tracking symptom progression and severity
  - Dementia Severity Rating Scale
  - Neuropsychiatric Inventory (NPI)
  - Alzheimer's Association Provider Toolkit
- How aggressively do you want to treat other medical concerns?
- Have you completed a POLST?
- Are there safety/capacity concerns?

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# DIRECTIONS FOR CLINICAL PRACTICE

(Reynolds, Jeste, Sachdev, & Blazer, 2022; p.343)

- Behavioral Health should be playing a major role in comprehensively assessing and treating cognitive concerns
- Clinical services and diagnostic pathways should be improved to facilitate early and accurate diagnosis
- Better models of collaborative care for dementia and cognitive concerns should be developed to support immediately after diagnosis and in the longer term
- Encourage healthy behaviors – what's good for the body is good for the brain!

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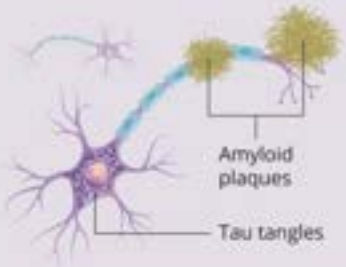
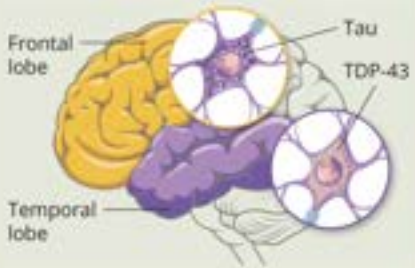
# Understanding Different Types of Dementia

As we age, it's normal to lose some neurons in the brain. People living with dementia, however, experience far greater loss. Many neurons stop working, lose connections with other brain cells, and eventually die. At first, symptoms can be mild, but they get worse over time. Read on to learn more about four different types of dementia.

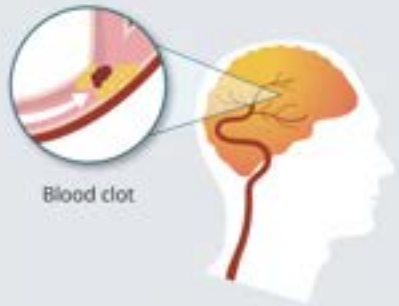
## TYPES OF DEMENTIA

| Alzheimer's Disease | Frontotemporal Dementia | Lewy Body Dementia | Vascular Dementia |
|---|---|---|---|
| **What Is Happening in the Brain?*** | | | |
| Abnormal deposits of proteins form amyloid plaques and tau tangles throughout the brain. | Abnormal amounts or forms of tau and TDP-43 proteins accumulate inside neurons in the frontal and temporal lobes. | Abnormal deposits of the alpha-synuclein protein, called "Lewy bodies," affect the brain's chemical messengers. | Conditions, such as blood clots, disrupt blood flow in the brain. |








*These changes are just one piece of a complex puzzle that scientists are studying to understand the underlying causes of these forms of dementia and others.

(NIH: National Institute of Health, 2025)

# ACTIVITIES AND PROGRAMS FOR PEOPLE LIVING WITH DEMENTIA - SOCIAL


(https://depts.washington.edu/mbwc/resources/dementia-friendly-programs)

# DRIVING

The challenge with driving and dementia is to preserve a person's sense of independence for as long as possible, while simultaneously protecting the safety of that person and others.

- **Consider the frequency and severity of incidents.** Several minor incidents or an unusual, major incident may warrant action.
- **Look for *patterns* of change over time.** Isolated or minor incidents do not warrant immediate or drastic action.
- **Avoid an alarming reaction.** Take notes and have conversations at a later, convenient time, rather than during or immediately after an incident
- At the Crossroads - Family Conversations about Alzheimer's Disease, Dementia, and Driving
- Washington State Department of Licensing – Report Unsafe Drivers

# ADVANCE CARE PLANNING

- Dementia Directive
- Dementia Care Navigation Service
- Alzheimer's Association 24/7 Help Line
  - 1.800.272.3900
- Legal and financial planning

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# COMMUNICATION RESOURCES

- Listent with Respect, Comfort, and Redirect
- Alzheimer's Association Communication Tips
- VA Dementia Care Resources
- Dementia Roadmap



## Listen with Respect; Comfort and Redirect (LRCR)

After introducing yourself at the beginning of the interaction, use the following communication skills:

### 1. Listen

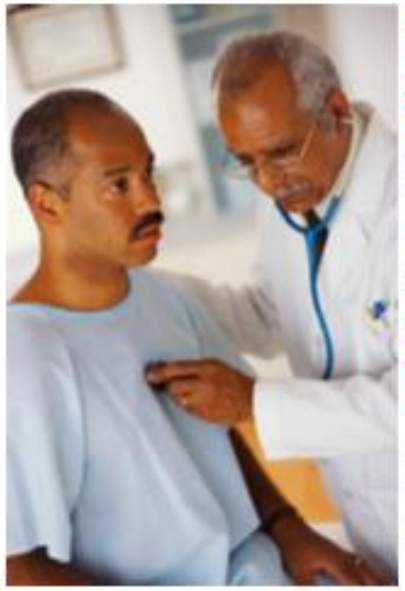
Make sure that the resident KNOWS you are listening.

- Make eye contact with the resident.
- Focus on the resident; don't try to do two things at once.

### 2. Respect

Sometimes being too casual with residents can be viewed as disrespect.

- Start with formality
- Later, ask the resident how he or she likes to be addressed.
- Pay attention to the resident's nonverbal communication. If he or she is bothered by your communication style try a different way.



### 3. Comfort

What we say and how we say it can provide comfort to residents who are anxious or depressed.

- Pay more attention to what the resident may be thinking or feeling than what he or she might be saying.
- Let the resident know that you understand.
- Persons with dementia who are anxious and depressed need help to calm down.

### 4. Redirect

Sometimes providing comfort is not enough. Try to redirect or distract the resident from his or her problem behavior.

- Attempt to change the subject after you have shown respect and tried comfort measures.
- Try to involve the resident in pleasant events.
- Whatever you do, DON'T ARGUE.

*Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.*

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