Health care professionals play a key supportive role for people with dementia and their care partners. They can promote early detection and diagnosis and provide ongoing medical care, as well as educate patients about dementia and connect people with the disease and their care partners with community resources that promote quality of life.

Ready to implement dementia friendly practices? Follow the steps:

1. Prepare
   - Recognize the signs of dementia.
   - Identify champions at the leadership level to sustain the initiative, and on-the-ground, “go-to” resources in clinics or departments.
   - Implement a coordinated, person-centered approach for all aspects of dementia care.

2. Learn
   - Learn to use dementia friendly communication skills.
   - Understand the benefits of early detection and diagnosis.
   - Know about tools available to quickly detect cognitive impairment and local services that deal with all stages of disease.
   - Provide ongoing dementia education for all staff.

3. Respond
   - Assess cognitive health using objective assessments such as the Mini-Cog’ or Montreal Cognitive Assessment (MoCA)², provide a complete dementia workup, and disclose and document diagnosis.

Continued on next page
Respond (cont.)

- Explain diagnosis and disease process, including possible treatments, what to expect with memory loss and behavior changes, and ideas for staying active and engaged.
- Encourage people with dementia and their care partners to connect with others and engage in health and wellness activities.
- Refer to specialists and resources for counseling, education, and planning.
- Support care partners and recognize and respond to signs of burnout.
- Develop a person-centered care plan that maximizes abilities, function, and quality of life; manages medications and chronic disease; provides referrals to services and support; supports care partner needs; addresses home and personal safety and independence (e.g., fall risk, mobility/sensory needs, driving); facilitates advance care, financial, and legal planning; and promotes positive behavioral health.
- Report suspected abuse, neglect, or financial exploitation.
- Spread practice guidelines to other members of your health care teams and referral networks.
- Encourage people with dementia and their care partners to connect with others and engage in health and wellness activities.

Signs of Dementia

- Memory loss that disrupts daily life.
- Challenges in planning or solving problems.
- Difficulty completing familiar 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 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.

Dementia Friendly Communication Skills

- Slow pace slightly and allow time for person to process and respond.
- Be aware of your body language: smile and make eye contact at eye level.
- Use shorter simple sentences, and ask one question at a time.
- Seek to understand person’s reality or feelings.
- Speak clearly and calmly; be patient and understanding; listen.
- Apologize and redirect to another environment or subject as needed.
- Avoid arguing with or embarrassing the person.
- Treat the person with dignity and respect.
Benefits of Early Detection and Diagnosis

- Brings personal relief from better understanding, knowing diagnosis.
- Maximizes time to make decisions and plan for the future.
- Person can access services and support early on.
- Reduces risks.
- Can prevent or reduce future financial costs.
- Improves clinical outcomes and medical management.

Person-Centered Care Planning for Dementia

1. How to maximize abilities, function and quality of life:
   - Treat conditions that may worsen symptoms or lead to poor outcomes, including depression and co-existing medical conditions.
   - Encourage patient to stop smoking and limit alcohol.
   - Recommend occupational and/or physical therapists who can give patients strategies for staying independent as the disease progresses.
   - Encourage lifestyle changes that may reduce disease symptoms or slow their progression.
   - Encourage routines for regular physical activity and healthy eating.
   - Address sensory issues or impairments.
   - Encourage socialization and engagement in activities the patient enjoys.

2. Medication therapy and chronic disease management:
   - Review and simplify prescribed and over-the-counter medications, including vitamins and herbal remedies; refer to pharmacist as needed.
   - Create a medication management plan that educates patient and care partner on medication management aids (pill organizers, dispensers, alarms).
   - Recommend that a care partner or health care professional oversee/dispense medications as needed.
   - Avoid or minimize anticholinergics, hypnotics (benzodiazepines, zolpidem), H2-receptor antagonists, and antipsychotics.
   - Evaluate the medications for over- and underuse and inappropriate or unsafe prescriptions.
   - Reassess the value of any medications, including those being used for cognitive symptoms; consider a slow taper if continued benefit is unclear.

3. Refer patient to services and support:
   - Indoor and outdoor chore services, home-delivered meals, transportation, and other assistance as needed.
   - See additional resources and Community Based Services and Supports sector guide.

4. Assess and support care partner needs:
   - Refer care partners to local resources – such as support groups, respite care, care partner education and training programs, and care partner coaching services – and encourage them to use them.
   - Remind care partners to take care of their own health and well-being, including through regular medical checkups.
   - Encourage care partners to talk with others about the diagnosis so people can understand a care partner’s role and provide support.
   - Encourage care partners to ask for help from family and friends.

5. Home and personal safety and independence:
   - Refer patient to an occupational and/or physical therapist to address fall risk, recommendations for sensory/mobility aids, home safety and accessibility modifications, and/or driving evaluation.
   - Refer patient to driving rehabilitation specialist for clinical and/or in-vehicle evaluation.
6. Facilitate advance care planning and end-of-Life care:
   - Discuss care goals, values and preferences with person with dementia and family.
   - Encourage patient and family to discuss and document preferences for care early on to prepare for later stages when patient is unable to make decisions.
   - Recommend that patient complete a healthcare directive and legal and financial planning and documents, and assign a durable power of attorney.
   - Complete POLST (Provider Orders for Life Sustaining Treatment) when appropriate, and routinely re-evaluate and modify plan of care as appropriate.
   - Discuss the role of palliative care and hospice in addressing pain and suffering.

7. Promote positive behavioral health:
   - Rule out delirium for any acute changes in behavior.
   - Describe and categorize the behavior, keeping in mind that behavior is a way to communicate.
   - Identify and address unmet needs or reversible conditions.
   - Simplify environment – remove clutter, stimuli.
   - Support care partner self care, respite, and education on tactics for things like minimizing confrontation and arguing.
   - Initiate non-pharmacologic approaches that may reduce symptoms:
     - Plan activities that involve preserved capabilities, interests, repetitive motion.
     - Give the person with dementia “tasks” that match his/her level of competency.
     - Train care partners to communicate, validate, redirect, and re-approach.
     - Reinforce that routine is essential.
   - Control the level of stimulation in the person’s environment.
   - Assess the efficacy of an approach.
   - Consider pharmacologic intervention only when non-pharmacologic interventions consistently fail or person is in danger of doing harm to self or others or experiencing intolerable psychiatric suffering.
   - There is no FDA-approved medication for Behavioral and Psychological Symptoms of Dementia nor strong scientific evidence to support any particular class of medications. If you use them, document informed consent in medical record and counsel care partners to watch for decreased functional or cognitive status, sedation, falls or delirium.
   - Attempt to wean or discontinue medication as soon as possible.
   - Monitor target behaviors to evaluate efficacy of medication.
Signs of inadequate patient support or overburdened care partner:

- Poor medication adherence.
- Weight loss.
- Falls.
- Wandering and being found by neighbors or police.
- Missing appointments.
- Decreased attention to hygiene and grooming.
- Unhelpful visits to urgent care/emergency room.

References

1. Alzheimer’s Association, Mini-Cog
   http://www.alz.org/documents_custom/minicog.pdf
2. MoCA - Montreal Cognitive Assessment
   http://www.mocatest.org/
3. Alzheimer’s Association, Know the 10 Signs
   http://www.alz.org/alzheimers_disease_10_signs_of_alzheimers.asp
4. Alzheimer’s Society, Communicating
   https://www.alzheimers.org.uk/info/20064/symptoms/90/communicating_and_language
5. Home Instead Business Training, Alzheimer’s Friendly Business online course
7. Lazaroff, A., et al. Using Dementia as the Organizing Principle when Caring for Patients with Dementia and Comorbidities, January 2013, Minnesota Medicine

Additional Resources

Alzheimer’s Association

- Activity Resources
- Caregiver Center
  http://www.alz.org/care/
- Community Resource Finder
  http://www.communityresourcefinder.org
- Dementia and Driving Resource Center
  http://www.alz.org/driving
- Increasing Disclosure of Dementia Diagnosis
  http://www.alz.org/documents_custom/inbrief_disclosure.pdf
- Healthcare Professionals and Alzheimer’s Resources
  http://www.alz.org/hcps
- Living Well: A Guide for Persons with Mild Cognitive Impairment (MCI) & Early Dementia
- MedicAlert® and Safe Return®
- Online Social Support Community: ALZConnected
  https://www.alzconnected.org/
- Residential Care
- Respite Care
- Safety Center
  http://www.alz.org/safety
- Stages of Alzheimer’s
- Support for People with Dementia
  http://www.alz.org/mnnd/in_my_community_18497.asp
- Taking Action: A Personal and Practical Guide for
Persons with Mild Cognitive Impairment (MCI) and Early Alzheimer's Disease

- 24/7 Helpline, 1-800-272-3900
  http://www.alz.org

Administration on Aging

- Eldercare Locator
  http://www.eldercare.gov/Eldercare.NET/Public/index.aspx
- National Center on Elder Abuse
  https://ncea.acl.gov/
- National Family Caregiver Support Program
  https://www.acl.gov/programs/support-caregivers/national-family-caregiver-support-program

The Hartford Financial Services Group

- Understanding Dementia and Driving
  https://www.thehartford.com/resources/mature-market-excellence/dementia-driving
- At the Crossroads

National Association of Area Agencies on Aging

- Healthy Aging
  http://www.n4a.org/healthyaging

National Council on Aging

- Physical Activity Programs for Older Adults
  https://www.ncoa.org/center-for-healthy-aging/physical-activity/physical-activity-programs-for-older-adults/
- 2015 Falls Free National Falls Prevention Action Plan
- Adult Day Care Locator and Articles
  https://www.caring.com/local/adult-day-care

Others

- National Wellness Institute – Six Dimensions of Wellness
  http://www.nationalwellness.org/?page=Six_Dimensions
- Alzheimer’s Society, Eating and Drinking
  https://www.alzheimers.org.uk/infocentre/20029/daily_living/10/eating_and_drinking
- National Hospice and Palliative Care Organization (state by state advanced directive forms)
  http://www.caringinfo.org/j4a/pages/index.cfm?pageid=3289
- Gitlin LN, Kales, HC, Lyketsos CG. Nonpharmacologic management of behavioral symptoms in dementia.
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711645
- Validation Therapy
  http://www.youtube.com/watch?v=CrZXz10FcVM
  https://vfvalidation.org/what-is-validation/
- Mayo Clinic, Mild Cognitive Impairment (MCI)
  http://www.mayoclinic.org/diseases-conditions/mild-cognitive-impairment/home/ovc-20206082
- ACT Provider Practice Tools
  http://www.actonalz.org/provider-practice-tools
- Centers for Disease Control and Prevention, Physical Activity is Essential to Healthy Aging
  http://www.cdc.gov/physicalactivity/basics/older_adults/index.htm
- American Occupational Therapist Association – Find a Driving Specialist
  http://myaota.aota.org/driver_search/index.aspx
- National Institute on Aging, Alzheimer’s Disease Education and Referral Center, Home Safety for People with Alzheimer’s Disease
- National Alliance for Caregiving
  http://www.caregiving.org
- Caregiver Action Network
  http://www.caregiveraction.org
- AARP Caregiving Resource Center
  http://www.aarp.org/home-family/caregiving/?cmp=RDRCT-CRGVER_APR12_012
- Wolters Kluwer Uptodate, Delirium: Beyond the Basics
  http://www.uptodate.com/contents/delirium-beyond-the-basics
- American Geriatric Society, BEERS Criteria for Potentially Inappropriate Medication Use in Older Adults
- Stratis Health, How to Help Your Loved One: Improve Dementia Care by Reducing Unnecessary Antipsychotic Drugs
- Health in Aging, A Guide to Geriatric Syndromes: Common and Often Related Medical Conditions in Older Adults
- Hospice Criteria Card (2013)
- POLST (Provider Orders for Life Sustaining Treatment)
  http://www.polst.org/
Health care is just one important part of the community. Working alongside other sectors, health care professionals can help the whole community become more dementia friendly. Learn more about the process and help your community and others become more dementia friendly at www.dfamerica.org.

Adapted from ACT on Alzheimer’s® developed tools and resources.