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Dementia Cal MediConnect Project
CARE MANAGER MANUAL

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Dementia Cal MediConnect Project

Care Manager Manual

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California Department of Public Health

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PEOPLE WITH DEMENTIA IN THE COORDINATED CARE INITIATIVE'S DEMENTIA CAL MEDICONNECT PROJECT

Alzheimer's Disease: A Public Health Concern

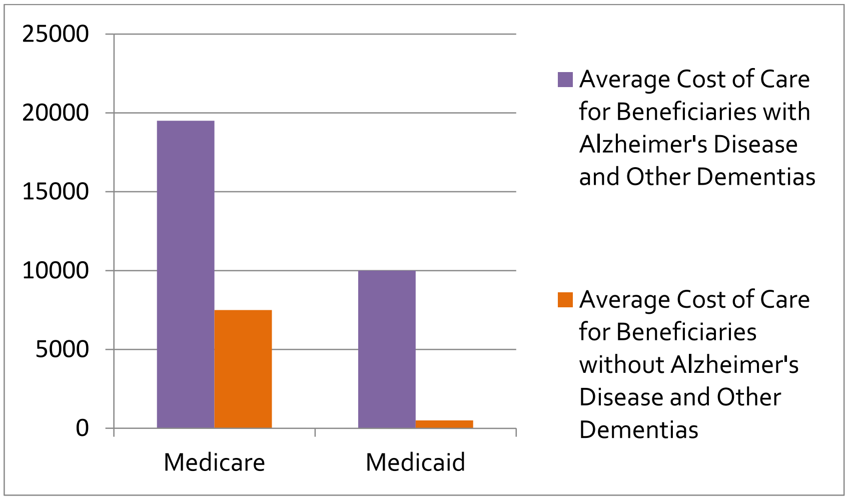
Alzheimer's disease currently afflicts an estimated 5.3 million Americans and about 600,000 Californians.[1] With the aging of the baby boomers, these numbers will double in less than twenty years and triple by mid-century. Hispanics and African Americans are one and a half to two times as likely to have Alzheimer's disease and other dementias.[2] Alzheimer's and other dementias have enormous health and economic consequences for patients, their family caregivers, and society.

People with Alzheimer's Disease and Related Disorders in Cal MediConnect

Based on prevalence data in the population aged 65 and older, Alzheimer's Greater Los Angeles conservatively estimates that 61,000 to 84,000 of dual eligible beneficiaries in California, and 19,000 in Los Angeles County alone, have Alzheimer's disease or a related dementia.[3]

Cost of Care

Beneficiaries with moderate to severe cognitive impairment, as shown in the chart below, cost Medicare three times more than other beneficiaries in the same age group; this difference is driven primarily by hospitalizations. They cost Medicaid nineteen times more than other enrollees of the same age, largely due to nursing home utilization.[4] Many people with dementia have multiple coexisting conditions.[5] This increases the likelihood for hospitalization and length of hospital stays, compared to people with the same serious medical conditions, but without dementia.[6]



Caregiving

In 2014, there were over 1.5 million family caregivers in California who provided over $20 billion worth of unpaid care.[7] Effectively managing the health care of a person with dementia cannot be done without the active participation of family caregivers; this means more than simply involving them in the patient's health decisions. Caring for a person with Alzheimer's or other dementias is often very difficult, and many family and other unpaid caregivers experience high levels of emotional stress, burnout, and depression. As a result, health plans must assess caregivers' ability to provide the necessary level of care, and identify the education and supportive services the caregivers need to be able to continue providing this level of care. In cases where caregivers are unable to provide the needed level of care, or where there is no caregiver, plans must develop comprehensive strategies to provide for the safety and well-being of the person with Alzheimer's.

Dementia Care Management Improves Care and Health Outcomes

There are now three randomized controlled studies that have examined ways to improve care while controlling costs for this vulnerable population.[8, 9, 10] They each recommend the training of a dementia care specialist who is assigned to educate and support patients and family caregivers, as well as connect them to needed services within the health care system and the community. The three-way contract[11] between the health plans, the State, and Centers for Medicare & Medicaid Services (CMS) mandate that each plan have specially designated care coordination staff in dementia care management to work with this complex population.

Key Components of Quality Managed Care

Quality managed care for people with dementia is possible to achieve. Much research has been done about the key components that must be in place in order to truly meet the needs of people with dementia. These components include:

- Screening to identify members with cognitive impairment;
- Training for healthcare professionals;
- Evidence-based practice guidelines for diagnosis, treatment, and management;
- Family caregiver assessments and supports; and,
- Dementia care management by a trained dementia-knowledgeable professional.

Dementia Cal MediConnect Project

Funded by the federal Administration on Community Living through California's Department of Aging, the Dementia Cal MediConnect Project seeks to improve the quality of health care for members enrolled in Cal MediConnect health plans. This is achieved through consultation to the plans and training for care managers and family caregivers, provided by Alzheimer's Greater Los Angeles, Alzheimer's San Diego, and the Alzheimer's Association, Northern California and Northern Nevada Chapter.

As California moves forward with the overall Coordinated Care Initiative, key components of quality managed care must be in place. Only then will the Initiative achieve its goals of improving patient health and lowering health care costs. The costs - to families, to our communities, and to the State - of not doing so are enormous.

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Alzheimer’s Disease and Related Dementias

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Alzheimer's Disease and Other Dementias

Dementia is the loss of cognitive functioning, which means the loss of the ability to think, remember, reason, as well as behavioral abilities, to such extent that it interferes with a person's daily life and activities. Dementia is a general term that refers to a group of symptoms, and there are several different types of dementia. Alzheimer's disease is the most common type of Dementia, which is why we hear this term most often.

Alzheimer's disease is an irreversible brain disorder that gets worse over time. It slowly destroys memory and thinking skills and, eventually, the ability to carry out simple tasks. Alzheimer's affects people's ability to communicate, think, problem-solve, behave, and function physically. In addition, some people with dementia cannot control their emotions, their personalities may change, they can have delusions (strong beliefs without proof, such as the idea that someone is stealing from them) and may also have hallucinations (seeing or hearing things that are not really there.)

Signs and Symptoms

Memory problems are usually one of the first signs of cognitive impairment related to Alzheimer's disease. Symptoms can vary from person to person and will change throughout the progression of the disease.

Mild Alzheimer's Disease

As Alzheimer's disease progresses, people experience greater memory loss and other cognitive difficulties. Problems can include wandering and getting lost, trouble handling money and paying bills, repeating questions, taking longer to complete normal daily tasks, and personality and behavior changes.

Moderate Alzheimer's Disease

In this stage, damage occurs in areas of the brain that control language, reasoning, sensory processing, and conscious thought. Memory loss and confusion grow worse, and people begin to have problems recognizing family and friends. They may be unable to learn new things, carry out multi-step tasks such as getting dressed, or cope with new situations. In addition, people at this stage may have hallucinations, delusions, and paranoia and may behave impulsively.

Severe Alzheimer's Disease

People with severe Alzheimer's cannot communicate and are completely dependent on others for their care. Near the end, the person may be in bed most or all of the time as the body shuts down.

Vascular Dementia

Vascular dementia is caused by injuries to the vessels supplying blood to the brain. These disorders can be caused by brain damage from multiple strokes or any injury to the vessels carrying blood to the brain. Dementia risk can be significant even when individuals have suffered only small strokes. Vascular dementia arises as a result of risk factors that similarly increase the risk for stroke, including atrial fibrillation, hypertension, diabetes, and high cholesterol. Symptoms of vascular dementia and VCI can begin suddenly and progress or subside during one's lifetime.

Lewy Body Dementia (DLB)

DLB is one of the more common forms of dementia. Symptoms such as difficulty sleeping, loss of smell, and visual hallucinations often come before movement and other problems by as long as 10 years, which consequently results in DLB going unrecognized or misdiagnosed as a psychiatric disorder until its later stages.

Later in the course of DLB, some signs and symptoms are similar to Alzheimer's disease and may include memory loss, poor judgment, and confusion. Other signs and symptoms of DLB are similar to those of Parkinson's disease, including difficulty with movement and posture, a shuffling walk, and changes in alertness and attention. Given these similarities, DLB can be very difficult to diagnose. There is no cure for DLB, but there are drugs that control some symptoms. The medications used to control DLB symptoms can make motor function worse or exacerbate hallucinations.

Frontotemporal Dementia (FTD)

In FTD, changes to nerve cells in the brain's frontal lobes affect the ability to reason and make decisions, prioritize and multitask, act appropriately, and control movement. Some people decline rapidly over 2 to 3 years, while others show only minimal changes for many years. People can live with frontotemporal disorders for 2 to 10 years, sometimes longer, but it is difficult to predict the time course for an affected individual.

In some cases, FTD is associated with progressive neuromuscular weakness otherwise known as amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease). The signs and symptoms may vary greatly among individuals as different parts of the brain are affected. No treatment that can cure or reverse FTD is currently available.

Parkinson's Disease Dementia (PDD)

Parkinson's disease dementia is a clinical diagnosis related to DLB that can occur in people with Parkinson's disease. PDD may affect memory, social judgment, language, or reasoning. Autopsy studies show that people with PDD often have amyloid plaques and tau tangles similar to those found in people with AD, though it is not understood what these similarities mean. A majority of people with Parkinson's disease develop dementia, but the time from the onset of movement symptoms to the onset of dementia symptoms varies greatly from person to person. Risk factors for developing PDD include the onset of Parkinson's-related movement symptoms followed by mild cognitive impairment and REM sleep behavior disorder, which involves having frequent vivid nightmares and visual hallucinations.

Mixed Dementia

Autopsy studies looking at the brains of people who had dementia suggest that a majority of those age 80 and older probably had "mixed dementia," caused by both AD-related neurodegenerative processes and vascular disease-related processes. In fact, some studies indicate that mixed vascular-degenerative dementia is the most common cause of dementia in the elderly. In a person with mixed dementia, it may not be clear exactly how many of a person's symptoms are due to AD or another type of dementia. In one study, approximately 40 percent of people who were thought to have AD were found after autopsy to also have some form of cerebrovascular disease. Several studies have found that many of the major risk factors for vascular disease also may be risk factors for AD.

Huntington's Disease

This hereditary disorder is caused by a faulty gene for a protein called huntingtin. Symptoms begin around age 30 or 40 years and include abnormal and uncontrollable movements called chorea, as well as gait changes and lack of coordination. Huntington's disease may affect a person's judgment, memory, and other cognitive functions. As the disease progresses, these cognitive problems worsen, and motor difficulties lead to complete loss of ability for self-care. Children of people with Huntington's disease have a 50 percent chance of having the disorder.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
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Causes and Risk Factors

What Causes Alzheimer's

Scientists don't yet fully understand what causes Alzheimer's disease in most people. In people with early-onset Alzheimer's, a genetic mutation is usually the cause. Late-onset Alzheimer's arises from a complex series of brain changes that occur over decades. The causes probably include a combination of genetic, environmental, and lifestyle factors. The importance of any one of these factors in increasing or decreasing the risk of developing Alzheimer's may differ from person to person.

The Basics of Alzheimer's

Scientists are conducting studies to learn more about plaques, tangles, and other biological features of Alzheimer's disease. Advances in brain imaging techniques allow researchers to see the development and spread of abnormal amyloid and tau proteins in the living brain, as well as changes in brain structure and function. Scientists are also exploring the very earliest steps in the disease process by studying changes in the brain and body fluids that can be detected years before Alzheimer's symptoms appear. Findings from these studies will help in understanding the causes of Alzheimer's and make diagnosis easier.

One of the great mysteries of Alzheimer's disease is why it largely strikes older adults. Research on normal brain aging is shedding light on this question. For example, scientists are learning how age-related changes in the brain may harm neurons and contribute to Alzheimer's damage. These age-related changes include atrophy (shrinking) of certain parts of the brain, inflammation, production of unstable molecules called free radicals, and mitochondrial dysfunction (a breakdown of energy production within a cell).

Genetics

Most people with Alzheimer's have the late-onset form of the disease, in which symptoms become apparent in their mid-60s. The apolipoprotein E (APOE) gene is involved in late-onset Alzheimer's. This gene has several forms. One of them, APOE ε4, increases a person's risk of developing the disease and is also associated with an earlier age of disease onset. However, carrying the APOE ε4 form of the gene does not mean that a person will definitely develop Alzheimer's disease, and some people with no APOE ε4 may also develop the disease.

Also, scientists have identified a number of regions of interest in the genome (an organism's complete set of DNA) that may increase a person's risk for late- onset Alzheimer's to varying degrees. Early-onset Alzheimer's disease occurs in people age 30 to 60 and represents less than 5 percent of all people with Alzheimer's. Most cases are caused by an inherited change in one of three genes, resulting in a type known as early-onset familial Alzheimer's disease, or FAD. For others, the disease appears to develop without any specific, known cause, much as it does for people with late-onset disease.

Most people with Down syndrome develop Alzheimer's. This may be because people with Down syndrome have an extra copy of chromosome 21, which contains the gene that generates harmful amyloid.

For more about Alzheimer's genetics research, see the **Alzheimer's Disease Genetics Fact Sheet**, available at *www.nia.nih.gov/alzheimers/ publication/alzheimers-disease- genetics-fact-sheet.*

Health, Environmental, and Lifestyle Factors

Research suggests that a host of factors beyond genetics may play a role in the development and course of Alzheimer's disease. There is a great deal of interest, for example, in the relationship between cognitive decline and vascular conditions such as heart disease, stroke, and high blood pressure, as well as metabolic conditions such as diabetes and obesity. Ongoing research will help us understand whether and how reducing risk factors for these conditions may also reduce the risk of Alzheimer's.

A nutritious diet, physical activity, social engagement, and mentally stimulating pursuits have all been associated with helping people stay healthy as they age. These factors might also help reduce the risk of cognitive decline and Alzheimer's disease. Clinical trials are testing some of these possibilities.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012

FDA-Approved Treatments

Several prescription drugs are currently approved by the U.S. Food and Drug Administration (FDA) to treat people who have been diagnosed with Alzheimer's disease. Treating the symptoms of Alzheimer's can provide patients with comfort, dignity, and independence for a longer period of time and can encourage and assist their caregivers as well.

It is important to understand that none of these medications stops the disease itself.

Treatment for Mild to Moderate Alzheimer's

Medications called cholinesterase inhibitors are prescribed for mild to moderate Alzheimer's disease. These drugs may help delay or prevent symptoms from becoming worse for a limited time and may help control some behavioral symptoms. The medications include Razadyne® (galantamine), Exelon® (rivastigmine), and Aricept® (donepezil).

Scientists do not yet fully understand how cholinesterase inhibitors work to treat Alzheimer's disease, but research indicates that they prevent the break- down of acetylcholine, a brain chemical believed to be important for memory and thinking. As Alzheimer's progresses, the brain produces less and less acetylcholine; therefore, cholinesterase inhibitors may eventually lose their effect. No published study directly compares these drugs. Because they work in a similar way, switching from one of these drugs to another probably will not produce significantly different results. However, an Alzheimer's patient may respond better to one drug than another.

Treatment for Moderate to Severe Alzheimer's

A medication known as Namenda® (memantine), an N-methyl D-aspartate (NMDA) antagonist, is prescribed to treat moderate to severe Alzheimer's disease. This drug's main effect is to delay progression of some of the symptoms of moderate to severe Alzheimer's. It may allow patients to maintain certain daily functions a little longer than they would without the medication. For example, Namenda® may help a patient in the later stages of the disease maintain his or her ability to use the bathroom independently for several more months, a benefit for both patients and caregivers.

The FDA has also approved Aricept® and Namzaric®, a combination of Namenda® and donepezil, for the treatment of moderate to severe Alzheimer's disease.

Namenda® is believed to work by regulating glutamate, an important brain chemical.

Medications to Treat Alzheimer's Disease

This brief summary does not include all information important for patient use and should not be used as a substitute for professional medical advice. Consult the prescribing doctor and read the package insert before using these or any other medications or supplements.

DRUG NAME	DRUG TYPE AND USE	HOW IT WORKS	COMMON SIDE EFFECTS
Aricept® (donepezil)	Cholinesterase inhibitor prescribed to treat symptoms of mild, moderate, and severe Alzheimer's	Prevents the breakdown of acetylcholine in the brain	Nausea, vomiting, diarrhea, muscle cramps, fatigue, weight loss
Exelon® (rivastigmine)	Cholinesterase inhibitor prescribed to treat symptoms of mild to moderate Alzheimer's (patch is also for severe Alzheimer's)	Prevents the breakdown of acetylcholine and butyrylcholine (a brain chemical similar to acetylcholine) in the brain	Nausea, vomiting, diarrhea, weight loss, decreased appetite, muscle weakness
Namenda® (memantine)	N-methyl D-aspartate (NMDA) antagonist prescribed to treat symptoms of moderate to severe Alzheimer's	Blocks the toxic effects associated with excess glutamate and regulates glutamate activation	Dizziness, headache, diarrhea, constipation, confusion
Namzaric® (memantine extended- release and donepezil)	NMDA antagonist and cholinesterase inhibitor prescribed to treat symptoms of moderate to severe Alzheimer's	Blocks the toxic effects associated with excess glutamate and prevents the breakdown of acetylcholine in the brain	Headache, nausea, vomiting, diarrhea, dizziness, decreased appetite
Razadyne® (galantamine)	Cholinesterase inhibitor prescribed to treat symptoms of mild to moderate Alzheimer's	Prevents the breakdown of acetylcholine and stimulates nicotinic receptors to release more acetylcholine in the brain	Nausea, vomiting, diarrhea, weight loss, decreased appetite

Medications to Treat Alzheimer's Disease

(Continued)

DRUG NAME	MANUFACTURER'S RECOMMENDED DOSAGE	MORE INFORMATION
Aricept® (donepezil)	Tablet*: Initial dose of 5 mg once a day May increase dose to 10 mg/day after 4-6 weeks if well tolerated, then to 23 mg/day after at least 3 months Orally disintegrating tablet*: Same dosage as above 23-mg dose available as brand-name tablet only	For current information about this drug's safety and use, visit www.aricept.com/prescribing-and- patient-info Click on "Prescribing and Patient Information" to see the drug label.
Exelon® (rivastigmine)	Capsule*: Initial dose of 3 mg/day (1.5 mg twice a day) May increase dose to 6 mg/day (3 mg twice a day), 9 mg (4.5 mg twice a day), and 12 mg/day (6 mg twice a day) at minimum 2-week intervals if well tolerated Patch: Initial dose of 4.6 mg once a day; may increase dose to 9.5 mg once a day and 13.3 mg once a day at minimum 4-week intervals if well tolerated Oral solution: Same dosage as capsule	For current information about this drug's safety and use, visit www.fda.gov/Drugs. Click on "Drugs@FDA," search for Exelon, and click on drug-name links to see "Label Information."
Namenda® (memantine)	Tablet: Initial dose of 5 mg once a day May increase dose to 10 mg/day (5 mg twice a day), 15 mg/day (5 mg and 10 mg as separate doses), and 20 mg/day (10 mg twice a day) at minimum 1-week intervals if well tolerated Oral solution: Same dosage as above Extended-release capsule: Initial dose of 7 mg once a day; may increase dose to 14 mg/day, 21mg/day, and 28 mg/day at minimum 1-week intervals if well tolerated	For current information about this drug's safety and use, visit www.namenda.com. Click on "Full Prescribing Information" to see the drug label.
Namzaric® (memantine extended- release and donepezil)	Capsule: 28 mg memantine extended-release + 10 mg donepezil once a day 14 mg memantine extended-release + 10 mg donepezil once a day (for patients with severe renal impairment)	For current information about this drug's safety and use, visit www.namzaric.com. Click on "Prescribing Information" to see the drug label.

Medications to Treat Alzheimer's Disease

(Continued)

DRUG NAME	MANUFACTURER'S RECOMMENDED DOSAGE	MORE INFORMATION
Razadyne® (galantamine)	Tablet*: Initial dose of 8 mg/day (4 mg twice a day) May increase dose to 16 mg/day (8 mg twice a day) and 24 mg/day (12 mg twice a day) at minimum 4-week intervals if well tolerated Oral solution*: Same dosage as above Extended-release capsule*: Same dosage as above but taken once a day	For current information about this drug's safety and use, visit www.janssenpharmaceuticals.com/assets/razadyneer.pdf to see the drug label.

*Available as a generic drug.

When produced in excessive amounts, glutamate may lead to brain cell death.

Because NMDA antagonists work very differently from cholinesterase inhibitors, the two types of drugs can be prescribed in combination.

Dosage and Side Effects

Doctors usually start patients at low drug doses and gradually increase the dosage based on how well a patient tolerates the drug. There is some evidence that certain patients may benefit from higher doses of the cholinesterase inhibitors. However, the higher the dose, the more likely are side effects. The recommended effective dosages of drugs prescribed to treat the symptoms of Alzheimer's and the drugs' possible side effects are summarized in the table (see inside).

Patients should be monitored when a drug is started. Report any unusual symptoms to the prescribing doctor right away. It is important to follow the doctor's instructions when taking any medication, including vitamins and herbal supplements. Also, let the doctor know before adding or changing any medications.

Testing New Alzheimer's Drugs

Clinical trials are the best way to find out if promising new treatments are safe and effective in humans. Volunteers are needed for many Alzheimer's trials conducted around the United States. To learn more, talk with your doctor or visit the ADEAR Center's listing of clinical trials at www.nia.nih.gov/alzheimers/clinical-trials. More information is available at www.nia.nih.gov/alzheimers/volunteer.

For More Information

To learn about support groups, research centers, research studies, and publications about Alzheimer's disease, contact the following resources:

Alzheimer's Disease Education and Referral (ADEAR) Center

1-800-438-4380 (toll-free) adear@nia.nih.gov *www.nia.nih.gov/alzheimers*

The National Institute on Aging's ADEAR Center offers information and publications for families, caregivers, and professionals on diagnosis, treatment, patient care, caregiver needs, long-term care, education, training, and research related to Alzheimer's disease. Staff members answer telephone, email, and written requests and make referrals to local and national resources. Visit the ADEAR website to learn more about Alzheimer's and other dementias, find clinical trials, and sign up for email alerts.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
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Assessment

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How to Find Out If It’s Alzheimer’s

Signs and Symptoms

Memory problems are typically one of the first signs of cognitive impairment related to Alzheimer’s disease. Some people with memory problems have a condition called mild cognitive impairment (MCI). In MCI, people have more memory problems than normal for their age, but their symptoms do not interfere with their everyday lives. Movement difficulties and problems with the sense of smell have also been linked to MCI. Older people with MCI are at greater risk for developing Alzheimer’s, but not all of them do. Some may even go back to normal cognition.

The first symptoms of Alzheimer’s vary from person to person. For many, decline in non-memory aspects of cognition, such as word-finding, vision/spatial issues, and impaired reasoning or judgment, may signal the very early stages of Alzheimer’s disease. Studies indicate that such early detection may be possible, but more research is needed before these techniques can be relied upon to diagnose Alzheimer’s disease in everyday medical practice.

Diagnosis of Alzheimer’s Disease

Doctors use several methods and tools to help determine whether a person who is having memory problems has “possible Alzheimer’s dementia” (dementia may be due to another cause) or “probable Alzheimer’s dementia” (no other cause for dementia can be found).

To diagnose Alzheimer’s, doctors may:

- Ask the person and a family member or friend questions about overall health, past medical problems, ability to carry out daily activities, and changes in behavior and personality
- Conduct tests of memory, problem solving, attention, counting, and language
- Carry out standard medical tests, such as blood and urine tests, to identify other possible causes of the problem
- Perform brain scans, such as computed tomography (CT), magnetic resonance imaging (MRI), or positron emission tomography (PET), to rule out other possible causes for symptoms.

These tests may be repeated to give doctors information about how the person’s memory and other cognitive functions are changing over time.

Alzheimer's disease can be definitively diagnosed only after death, by linking clinical measures with an examination of brain tissue in an autopsy. People with memory and thinking concerns should talk to their doctor to find out whether their symptoms are due to Alzheimer's or another cause, such as stroke, tumor, Parkinson's disease, sleep disturbances, side effects of medication, an infection, or a non-Alzheimer's dementia. Some of these conditions may be treatable and possibly reversible.

If the diagnosis is Alzheimer's, beginning treatment early in the disease process may help preserve daily functioning for some time, even though the underlying disease process cannot be stopped or reversed. An early diagnosis also helps families plan for the future. They can take care of financial and legal matters, address potential safety issues, learn about living arrangements, and develop support networks.

In addition, an early diagnosis gives people greater opportunities to participate in clinical trials that are testing possible new treatments for Alzheimer's disease or other research studies.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
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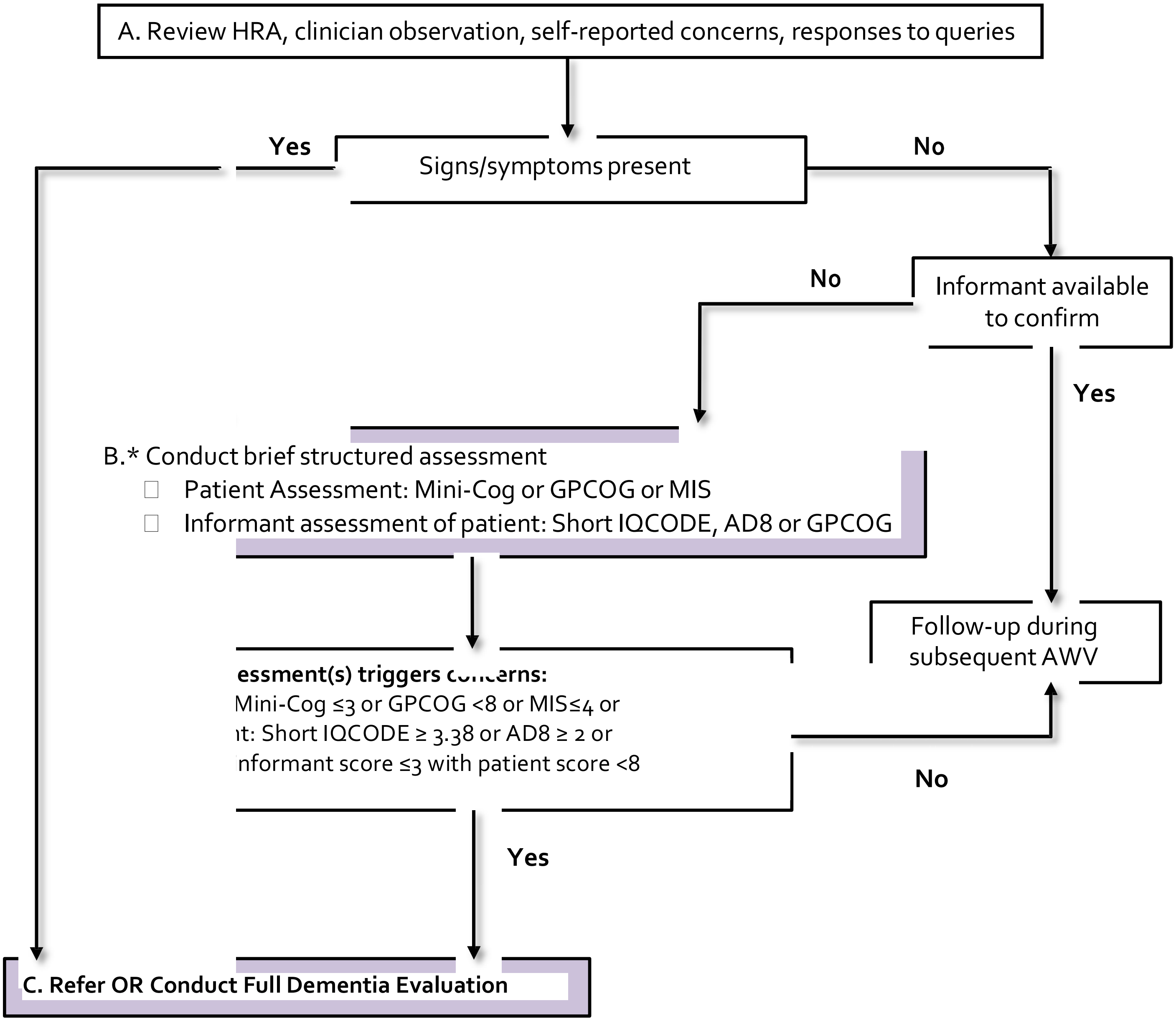


* No one tool is recognized as the best brief assessment to determine if a full dementia evaluation is needed. Some providers repeat patient assessment with an alternate tool (eg, SLUMS, or MoCA) to confirm initial findings before referral or initiation of full dementia evaluation.

AWV = Annual Wellness Visit; GPCOG = General Practitioner Assessment of Cognition; HRA = Health Risk Assessment; MIS = Memory Impairment Screen; MMSE = Mini Mental Status Exam; 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*. 2012. In press.

AD8 Dementia Screening Interview

Patient ID#:__________

CS ID#:____________
Date:___________

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., VCR, computer, microwave, 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			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564

The AD8 Administration and Scoring Guidelines

A spontaneous self-correction is allowed for all responses without counting as an error.

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.

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

Interpretation of the AD8 (Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564)

A screening test in itself is insufficient to diagnose a dementing disorder. The AD8 is, however, quite sensitive to detecting early cognitive changes associated many common dementing illness including Alzheimer disease, vascular dementia, Lewy body dementia and frontotemporal dementia.

Scores in the impaired range (see below) indicate a need for further assessment. Scores in the "normal" range suggest that a dementing disorder is unlikely, but a very early disease process cannot be ruled out. More advanced assessment may be warranted in cases where other objective evidence of impairment exists.

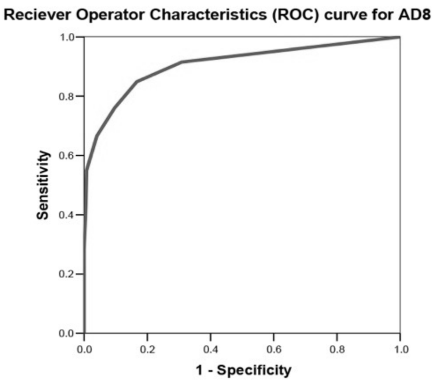
Based on clinical research findings from 995 individuals included in the development and validation samples, the following cut points are provided:

- 0 – 1: Normal cognition
- 2 or greater: Cognitive impairment is likely to be present

Administered to either the informant (preferable) or the patient, the AD8 has the following properties:

- Sensitivity > 84%
- Specificity > 80%
- Positive Predictive Value > 85%
- Negative Predictive Value > 70%

Area under the Curve: 0.908; 95%CI: 0.888-0.925


Reciever Operator Characteristics (ROC) curve for AD8

Permission Statement

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Cuestionario al informador AD8 (versión española)

Patient ID#: _______________
Date: _____________________

Con respecto a la persona a la que acompaña, ¿qué opina sobre los siguientes aspectos?:

Recuerde, "Sí, ha cambiado" significa que usted piensa que ha habido un cambio en los siguientes aspectos en los últimos años causado por problemas cognitivos (razonamiento y memoria)	**Sí**, Ha cambiado	**No**, No ha cambiado	**NS/NC** No sabe/ No contesta
1. Problemas para emitir juicios y tomar decisiones adecuadas (ej.: le engañan o timan, toma decisiones financieras erróneas, hace regalos inapropiados, etc.)			
2. Pérdida de interés en sus aficiones y actividades (ej.: ha dejado de hacer actividades que le gustaban)			
3. Repite las preguntas, los comentarios o las cosas que cuenta			
4. Dificultad para aprender a usar herramientas, aparatos o dispositivos (ej.: video o DVD, ordenador, microondas, mandos a distancia, teléfono móvil o inalámbrico)			
5. Olvida el mes o año correcto			
6. Dificultad para manejar asuntos financieros complicados (ej.: ajustar cuentas, talones, impuestos, facturas, recibos, etc.)			
7. Dificultad para recordar las citas y cosas que tiene que hacer			
8. Los problemas de razonamiento y/o memoria son cotidianos y no ocasionales			
TOTAL			

Permission granted by Carnero Pardo C, et al., at the Sociedad Española de Neurología. "Neurología 2012. doi:10.1016/j.nrl.2012.03.012" to reproduce *Cuestionario al informador AD8* in Care Manager Manual.

Management

Alzheimer's
GREATER LOS ANGELES

Guideline for Alzheimer's Disease Management

ASSESSMENT

Monitor Changes
Conduct and document an assessment and monitor changes in:

- Daily functioning, including feeding, bathing, dressing, mobility, toileting, continence, and ability to manage finances & medications
- Cognitive status using a reliable and valid instrument
- Comorbid medical conditions which may present with sudden worsening in cognition, function, or as change in behavior
- Behavioral symptoms, psychotic symptoms, and depression
- Medications, both prescription and non-prescription (at every visit)
- Living arrangement, safety, care needs, and abuse and/or neglect
- Need for palliative and/or end-of-life care planning

Reassess Frequently
Reassessment should occur *at least* every 6 months, and sudden changes in behavior or increase in the rate of decline should trigger an urgent visit to the PCP.

Identify Support
Identify the primary caregiver and assess the adequacy of family and other support systems, paying particular attention to the caregiver's own mental and physical health.

Assess Capacity
Assess the patient's decision-making capacity and determine whether a surrogate has been identified.

Identify Culture & Values
Identify the patient's and family's culture, values, primary language, literacy level, and decision-making process.

TREATMENT

Develop Treatment Plan
Develop and implement an ongoing treatment plan with defined goals. Discuss with patient and family:

- Use of cholinesterase inhibitors, NMDA antagonist, and other medications, if clinically indicated, to treat cognitive decline
- Referral to early-stage groups or adult day services for appropriate structured activities, such as physical exercise and recreation

Treat Behavioral Symptoms
Treat behavioral symptoms and mood disorders using:

- Non-pharmacologic approaches, such as environmental modification, task simplification, appropriate activities, etc.
- Referral to social service agencies or support organizations, including the *Alzheimer's Association's MedicAlert® + Safe Return®* program for patients who may wander

Non-Pharmacological Treatment First
IF non-pharmacological approaches prove unsuccessful, *THEN* use medications, targeted to specific behaviors, if clinically indicated. Note that side effects may be serious and significant.

Treat Co-Morbid Conditions
Provide appropriate treatment for comorbid medical conditions.

Provide End-of-Life Care
Provide appropriate end-of-life care, including palliative care as needed.

PATIENT & FAMILY EDUCATION & SUPPORT

Integrate Medical Care & Support
Integrate medical care with education and support by connecting patient and caregiver to support organizations for linguistically and culturally appropriate educational materials and referrals to community resources, support groups, legal counseling, respite care, consultation on care needs and options, and financial resources. *Organizations include:*

- **Alzheimer's Association**
  (800) 272-3900 www.alz.org
- **Family Caregiver Alliance**
  (800) 445-8106 www.caregiver.org
- or your own social service department

Discuss Diagnosis & Treatment
Discuss the diagnosis, progression, treatment choices, and goals of Alzheimer's Disease care with the patient and family in a manner consistent with their values, preferences, culture, educational level, and the patient's abilities.

Involve Early-Stage Patients
Pay particular attention to the special needs of early-stage patients, involving them in care planning, heeding their opinions and wishes, and referring them to community resources, including the Alzheimer's Association.

Discuss Stages
Discuss the patient's need to make care choices at all stages of the disease through the use of advance directives and identification of surrogates for medical and legal decision-making.

Discuss End-of-Life Decisions
Discuss the intensity of care and other end-of-life care decisions with the Alzheimer's Disease patient and involved family members while respecting their cultural preferences.

LEGAL CONSIDERATIONS

Planning
Include a discussion of the importance of basic legal and financial planning as part of the treatment plan as soon as possible after the diagnosis of Alzheimer's Disease.

Capacity Evaluations
Use a structured approach to the assessment of patient capacity, being aware of the relevant criteria for particular kinds of decisions.

Elder Abuse
Monitor for evidence of and report all suspicions of abuse (physical, sexual, financial, neglect, isolation, abandonment, abduction), as required by law.

Driving
Report the diagnosis of Alzheimer's Disease in accordance with law.

NATIONAL VERSION © April 2008

Guideline for Alzheimer's Disease Management

Alzheimer's Disease and Its Impact

Alzheimer's Disease (AD) currently afflicts over 5.2 million Americans, including an estimated 200,000 patients under the age of 65. The number of those afflicted is increasing annually as the population continues to age. Following the aging of the baby boomers, prevalence will escalate rapidly and is expected to double by 2020. The burden on families and the health care system will be substantial as one out of every eight baby boomers develops this disease.

About the Guideline

This Guideline presents core care recommendations for the management of Alzheimer's Disease. It assumes that a proper diagnosis has been made using reliable and valid diagnostic techniques. The main audience for the Guideline is primary care practitioners. However, many of the activities recommended in the Guideline do not require a physician and can be done by other members of the treatment team (care managers, nurses, community support organizations) working closely with the patient and caregiving family. The recommended activities do not have to be done in one visit.

The *California Workgroup on Guidelines for Alzheimer's Disease Management*, which consists of healthcare providers, consumers, academicians and representatives of professional and volunteer organizations, developed the Guideline through a review of scientific evidence supplemented by expert opinion when research has been unavailable or inconsistent. An expanded companion document, providing more in-depth background information, is available through the Alzheimer's Association's California website **www.caalz.org**.

Prepared by the
California Workgroup on Guidelines
for Alzheimer's Disease Management
Supported by the State of California,
Department of Public Health
April 2008

This is the third edition of this ***Guideline for Alzheimer's Disease Management.*** The first was disseminated in 1998 and updated in 2002. In the current version there are four substantive changes:

- The advent of a new class of medication (NMDA Antagonists) for the management of moderate to advanced AD
- Support for a team approach (medical and social support strategies) to quality management of AD
- Strong evidence linking positive patient outcomes to caregiver education and support
- New evidence on management of the disease in the very early and end stages (see the recommendations below)

Early-Stage Recommendations

Patients in early-stage AD have unique concerns. AD may progress slowly in the early stage. Follow up two months after diagnosis and every six months thereafter. Pay particular attention to the special needs of early-stage patients, involving them in care planning and referring them to community resources. Discuss implications with respect to work, driving, and other safety issues with the patient. Initiate pharmacologic therapy early. Recommend interventions to protect and promote continuing functioning, assist with independence, and maintain cognitive health including physical exercise, cognitive stimulation and psychosocial support.

Late Stage and End-of-Life Recommendations

As the patient's dementia worsens and the ability to understand treatments and participate in medical decision-making declines, care shifts to focus on the relief of discomfort. The advisability of routine screening tests, hospitalization, and invasive procedures, including artificial nutrition and hydration, will depend upon previously discussed care plan and the severity of the dementia. Predicting the end-of-life for a patient with severe AD is difficult. Referral to hospice should be considered.

Provider Checklist for Treating a Confused Older Adult

History and Physical

- ☐ Mental Status Exam (e.g. MMSE, Mini-Cog Test, MoCA (Montreal Cognitive Assessment))
- ☐ History of memory loss (e.g. sudden or gradual change, difficulty in performing familiar tasks, changes in personality or mood, psychiatric disorders)
- ☐ Assessment for mental illness
- ☐ Evaluate for depression and treat, if present
- ☐ A functional assessment of the patient including feeding, bathing, dressing, mobility continence, ability to manage finances and medications
- ☐ Assessment for substance abuse or medication mismanagement
- ☐ Assessment for recent physical trauma (e.g. falls, head injury, abuse)

Laboratory Tests

Routine lab tests:

- ☐ Complete Blood Count
- ☐ Electrolytes
- ☐ Blood Urea Nitrogen
- ☐ Creatinine
- ☐ Random Blood Sugar
- ☐ Calcium

Dementia screening tests:

- ☐ TSH
- ☐ B12

Contingent lab tests: (only order if patient's history indicates)

- ☐ Syphilis serology (MHA-TP or RPR)
- ☐ HIV

Diagnostic Tests

- ☐ PET, MRI or CT scan, if clinically indicated
- ☐ Rule out presence of delirium
- ☐ Physician review of lab and diagnostic tests (current)

Social and Safety Issues

- ☐ Assess if patient is safe to drive and report to local health department/DMV if indicated
- ☐ Assessment of decision making capacity
- ☐ Discuss Advance Directives
- ☐ Caregiver assessment which includes identification of primary caregiver, assessment of caregiver's capacity to manage person's needs (physically, emotionally, etc.) and assessment for elder abuse potential.

Refer to a social worker or Alzheimer's Greater Los Angeles for:

- ☐ Enrollment in MedicAlert® Found California (an identification program for memory impaired persons)
- ☐ Information on caregiver support groups as appropriate
- ☐ Information and education on dementia and disease course
- ☐ Referrals to adult day centers, respite services and information on legal and financial planning

This checklist is based, in part, on the *California Guideline for Alzheimer's Disease Management*. To receive a copy of the Guideline, contact Alzheimer's Greater Los Angeles

Challenging Behaviors

Alzheimer's
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Understanding Challenging Behaviors

People with Alzheimer's disease or other dementias often find it difficult to make sense of the world around them and communicate their needs. The way someone with dementia responds to things may look strange to us, but often there is meaning to their behaviors. If we want to understand a person with dementia, we need to figure out what the behavior means and address the person's needs. By understanding behaviors, we can often avoid difficult, stressful, and/or unsafe situations.

Some of the behaviors that caregivers and staff find most troubling are repetitive questions, wandering, nighttime restlessness, agitation, combativeness, incontinence, and accusations of theft. If these are familiar to you, you are not alone.

We are all different in how well we tolerate certain behaviors. By improving our understanding of what causes challenging behaviors, we can improve our tolerance, and even learn how to avoid them.

Understanding Challenging Behaviors

Understanding that challenging behaviors do not "just happen" is an important first step in dealing with them effectively. Behaviors are often an expression of an unmet need or a reaction to something.

Causes of challenging behaviors often fall into one of the following four categories:

1. Health Problems
2. Difficult Tasks
3. Confusing Environments
4. Communication Breakdowns

Health Problems

Medical problems and adverse drug reactions can sometimes cause challenging behaviors. If these health problems are treated, the behaviors may stop. Some examples include conditions such as dehydration, fatigue, and constipation.

Any sudden worsening of behavior may indicate a medication reaction or the presence of an acute illness such as a urinary tract infection or fever.

Remember that we cannot always rely on the person being cared for to tell us what is wrong. Whenever someone with dementia exhibits a sudden worsening in his or her behavior, they need to be taken to the doctor. The cause may be treatable.

Difficult Tasks

An unfamiliar or complicated task can be frustrating and trigger a challenging behavior. Remember that too many steps make a task complicated. Instructions which break down a task, step by step, are more likely to be successfully completed without causing unnecessary frustration. For example, if the person with dementia becomes upset when you ask him or her to get dressed, simplify the task by putting out only the clothes to be worn or giving him or her one item at a time.

Confusing Environments

Surroundings which are crowded, unfamiliar, busy, or noisy can be very distressing to the person with dementia. Choose places that are familiar, simple, well lit, and have lots of cues to help guide the person. For example, bathrooms should be clearly marked so they can be easily located.

Unfamiliar environments may be especially challenging to the disoriented or forgetful person. You may notice more difficult behaviors when the person with dementia goes to a new place or when you have visitors who change the routine.

Communication Breakdowns

People with dementia may have difficulty speaking and understanding what is said to them. To improve communication, go to a quiet location, speak slowly and simply, and use cues such as pointing to the bathroom when you ask if it is needed.

Remember that you set the tone. Avoid arguing. If you become irritated, excuse yourself and walk away for a moment. When you return, the person with dementia may have forgotten the conversation and you will be in a better position to calmly change the subject or distract him or her.

IDEA!

IDEA! is a simple three step strategy to help you figure out *why* a challenging behavior is happening and how to deal with it.

*ID*entify the problem/challenging behavior

- What is the behavior that is challenging for you to deal with? Be specific.
- Can you see it?

*E*ducate Yourself

Understand the cause of the behavior

- **Health:** Is the person taking a new medication, getting sick, or in pain?
- **Environment:** Is it too noisy? Is it too hot? Is the place unfamiliar?
- **Task:** Is the task too hard? Are there too many steps? Is it something new?
- **Communication:** Is it hard for the person to speak or understand?

Understand the meaning of the behavior to the person

- Does the person feel like he/she is being treated like a child?
- Are there things that remind the person of something unhappy?
- Does the person feel a sense of insecurity, discomfort, or boredom?

*A*dapt

Try different things. Pay attention to the person's feelings. Practice being calm, gentle, and reassuring.

- Distract or redirect by:
  - Offering the person something he/she likes to eat
  - Watching a TV show or listen to music
  - Asking the person for his/her help with a simple activity
  - Leading the person to a different room
- Address the cause or triggers of the behavior
  - Keep tasks and activities simple
  - Keep the home as quiet and calm as possible
  - Speak slowly and gently/try not to say too much at one time
  - Do not argue/try to comfort the person
  - Find meaningful, simple activities so the person is not bored

Difficulty with Bathing

At some point, people with Alzheimer's disease will need help bathing. Because this is a private activity, people may not want help. They may also feel angry about not being able to take care of themselves.

Helping someone with Alzheimer's disease take a bath or shower can be one of the hardest things you do. Planning can help make bath time better for both of you. If the person is afraid of bathing, follow his or her lifelong bathing habits, such as doing the bath or shower in the morning or before going to bed.

Safety Tips

To keep the person with Alzheimer's safe during bath time:

- Never leave a confused or frail person alone in the tub or shower.
- Always check the water temperature before he or she gets in the tub or shower.
- Use a hand-held showerhead.
- Use a rubber bath mat and safety bars in the tub.
- Use a sturdy shower chair to support a person who is unsteady and to prevent falls. You can buy shower chairs at drug stores and medical supply stores.

Before Bathing

Before starting a bath or shower:

- Get the soap, washcloth, towels, and shampoo ready.
- Make sure the bathroom is warm and well lighted.
- Play soft music if it helps to relax the person.
- Be matter-of-fact about bathing. Say, "It's time for a bath now." Don't argue about the need for a bath or shower.
- Be gentle and respectful. Tell the person what you are going to do, step by step.
- Make sure the water temperature is comfortable.

- Don't use bath oil. It can make the tub slippery and may cause urinary tract infections. During a Bath or Shower

Allow the person with Alzheimer's to do as much as possible. This protects his or her dignity and helps the person feel more in control. Here are other tips:

- Put a towel over the person's shoulders or lap. This helps him or her feel less exposed. Then use a sponge or washcloth to clean under the towel.
- Distract the person by talking about something else if he or she becomes upset.
- Give the person a washcloth to hold. This makes it less likely that he or she will try to hit you.

After Bathing

Try these suggestions:

- Prevent rashes or infections by patting the person's skin with a towel. Make sure the person is completely dry. Be sure to dry between folds of skin.
- If the person is incontinent, use a protective ointment, such as petroleum jelly, around the rectum, vagina, or penis.
- If the person has trouble getting in and out of the bathtub, do a sponge bath instead.

Other Bathing Tips

For most people, a full bath or shower two or three times a week is enough. Between full baths, a sponge bath to clean the face, hands, feet, underarms, and genitals is all you need to do every day. Also:

- Washing the person's hair in the sink with a hose attachment may be easier than doing it in the shower or bathtub.
- Get professional help with bathing if it becomes too hard for you to do on your own.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

WHY DOES THIS HAPPEN?

People with Alzheimer's or dementia might be:

- **afraid of falling**
- **feeling uneasy getting undressed in front of you**
- **scared or confused**
- **feeling helpless**

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...including the Inland Empire & south Ventura County

24/7 Helpline
844.HELP.ALZ
alzgla.org

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Bathing

People with Alzheimer's disease or dementia may be afraid of bathing or uneasy with having someone help them with bathing. Sometimes they worry about falling or can have trouble knowing which is the hot versus the cold water faucets.

WHAT CAN YOU DO?

Prepare the Bathroom in Advance

- make sure the room is calm and warm
- run the water so it is not too hot or too cold
- don't use bright lights if possible

Make the Bathroom Safe

- use a non-slip mat in the tub or shower and as a bath mat
- consider a tub seat
- fill the tub with only 4 inches of water
- remove things that may be dangerous such as razors, nail clippers, hair dryer, etc.
- watch carefully – don't leave him or her alone

Allow Time & Be Positive

- allow your person to enjoy it... if he or she finds bath time relaxing
- stay calm
- be direct... "Your bath is ready now" instead of "Do you want to take a bath?"
- give one step directions... "Let's wash your left arm...good!, now your other one"
- be patient... don't rush

Be Realistic

- don't argue or get frustrated... a daily bath may be too much
- consider a sponge bath instead of a tub bath
- show what you need from them... pretend to wash your arm so that he or she can copy

Bañarse

Personas con Alzheimer o demencia pueden tener miedo a bañarse. Creen que se van a caer o les da vergüenza desvestirse enfrente de otra persona.

¿QUÉ PUEDE HACER?

Primero prepare el baño

- asegúrese que el ambiente esté calmado y cómodo para la persona
- mantenga el agua a una temperatura agradable
- si es posible, no use luces brillantes

Seguridad en el baño

- use alfombras que no resbalen
- use una silla de baño
- ponga sólo 4 pulgadas de agua en la tina
- saque del baño lo que puede causarle daño a la persona con Alzheimer, tales como: rastrillos, corta úñas y secadoras de pelo
- nunca deje a la persona con Alzheimer sóla en la tina o ducha

Sea positivo, directo y paciente

- si a la persona le gusta bañarse, deje que disfrute su baño
- sea paciente, trate de no forzar ni apresurar a la persona
- de una instrucción a la vez…"Lávese el brazo. Bien. Ahora lávese el otro brazo"
- muéstrele con ejemplos; haga como que usted se lava el brazo y pida que copie sus movimientos

Evite las discusiones y sea realista

- un baño diario puede ser mucho
- considere un baño de esponja
- escoja una hora cuando la persona con Alzheimer esté relajada y no muy agitada

¿POR QUÉ PASA ESTE PROBLEMA?

Personas con Alzheimer o demencia pueden:

- **tener miedo a caerse**
- **no se sienten cómodos desvistiéndose enfrente de otros**
- **están asustados**
- **sentirse sin control**

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Supported by DHHS, ACL (#90AL0002-01-00)

Dressing and Grooming

When people feel good about how they look, they often feel better. Helping people with Alzheimer's disease brush their teeth, shave, put on makeup, and get dressed can help them feel more like themselves.

Mouth Care

Here are some tips to help the person with Alzheimer's care for his or her teeth and mouth.

- Show the person how to brush his or her teeth. Go step by step. Remember to let the person do as much as possible.
- Brush your teeth at the same time.
- Help the person clean his or her dentures.
- Ask the person to rinse his or her mouth with water after each meal and use mouthwash once a day.
- Try a long-handled, angled, or electric toothbrush if you need to brush the person's teeth.
- Take the person to see a dentist. Some dentists specialize in treating people with Alzheimer's. Ask the dentist how often the person should be seen.

Other Grooming

Here are some other suggestions for grooming:

- Encourage a woman to wear makeup if she has always used it. If needed, help her put on powder and lipstick. Don't use eye makeup.
- Encourage a man to shave, and help him as needed. Use an electric razor for safety.
- Take the person to the barber or beauty shop. Some barbers or hairstylists may come to your home.
- Keep the person's nails clean and trimmed.

Dressing

People with Alzheimer's disease often need more time to dress. It can be hard for them to choose their clothes. They might wear the wrong clothing for the season. They also might wear colors that don't go together or forget to put on a piece of clothing. Allow the person to dress on his or her own for as long as possible.

Other tips for dressing:

- Lay out clothes in the order the person should put them on, such as underwear first, then pants, then a shirt, and then a sweater.
- Hand the person one thing at a time, or give step-by-step dressing instructions.
- Put away some clothes in another room to reduce the number of choices. Keep only one or two outfits in the closet or dresser.
- Keep the closet locked if needed.
- Buy three or four sets of the same clothes if the person wants to wear the same clothing every day.
- Buy loose-fitting, comfortable clothing, such as sport bras, cotton socks and underwear, and sweat pants and shorts with elastic waistbands.
- Avoid girdles, control-top pantyhose, knee-high nylons, high heels, and tight socks.
- Use Velcro® tape or large zipper pulls for clothing instead of shoelaces, buttons, or buckles.
- Try slip-on shoes that won't slide off or shoes with Velcro® straps

Information adapted from the National Institute on Aging, part of the National Institutes of Health www.nia.nih.gov, NIH July 2012
Reviewed by ALZGLA November 2016

Difficulty with Eating

Eating healthy foods helps everyone stay well, but buying and preparing healthy foods can be challenging with someone who has Alzheimer's disease. A person with Alzheimer's may have difficulty with eating for several reasons. He or she may have a physical challenge with eating, there may be too many food options offered, or the person may forget that he or she already ate, or forget to eat all together. Here are some tips to help with healthy eating routines.

Buying and Preparing Food

When the person with Alzheimer's disease lives with you:

- Buy healthy foods such as vegetables, fruits, and whole-grain products. Be sure to buy foods that the person likes and can eat.
- Give the person choices about what to eat—for example, "Would you like green beans or salad?"
- Buy food that is easy to prepare, such as premade salads and single food portions.

Maintain Familiar Routines

Change can be difficult for a person with Alzheimer's disease. Maintaining familiar routines and serving favorite foods can make mealtimes easier. They can help the person know what to expect and feel more relaxed. If a home health aide or other professional provides care, family members should tell this caregiver about the person's preferences.

Try these tips:

- View mealtimes as opportunities for social interaction. A warm and happy tone of voice, in a calm and relaxing environment, can set the mood.
- Be patient and give the person enough time to finish the meal.
- Prepare the area ahead of time. Make sure the plate is a different color from the food, avoid patterns on placemats, plates and tablecloths. They can be distracting. And increase lighting in the eating area.
- Use bendable straws or cups with lids.
- Serve finger foods that are easier for the person to pick up and eat.
- Sit in front of the person when helping with eating. Use simple, gentle words.

Make eating simple. Try these options:

- Serve only one food at a time.
- Use bowls instead of plates.
- Set the area with only the utensils needed for the meal.

For Over-Eating

- Make sure the person is not sitting around with nothing to do. Try redirecting to activities that the person enjoys
- Try 5 or 6 small meals a day
- Have healthy snacks available, such as apples, carrots, etc.

For Under-Eating

- Talk with the doctor about possible illness, pain, or medication affects
- Check with the doctor about supplemental drinks, such as Ensure
- Offer the person a glass of juice before the meal to increase appetite
- Make sure the person is getting enough exercise
- Try to make foods the person likes
- Try feeding all of one food before moving to the next. Some people get confused by the change in texture or taste
- Be flexible. Let the person eat when he/she is hungry, if possible.

Stay Safe

In the early stage of Alzheimer's, people's eating habits usually do not change. When changes do occur, living alone may not be safe anymore. Look for these signs to see if living alone is no longer safe for the person with Alzheimer's:

- The person forgets to eat.
- Food has burned because it was left on the stove.
- The oven isn't turned off.

Information adapted from the National Institute on Aging, part of the National Institutes of Health www.nia.nih.gov, NIH July 2012
Reviewed by ALZGLA November 2016

Incontinence

A person with Alzheimer's disease may have other medical problems over time. These problems can cause more confusion and behavior changes. The person may not be able to tell you what is wrong.

One problem, incontinence, means a person can't control his or her bladder and/or bowels. This may happen at any stage of Alzheimer's disease, but it is more often a problem in the later stages. Signs of this problem are leaking urine, problems emptying the bladder, and soiled underwear and bed sheets. Let the doctor know if you see any of these signs. He or she may be able to treat the cause of the problem.

Causes of Incontinence

Incontinence has several possible causes. Some can be treated:

- Urinary tract infection
- Enlarged prostate gland
- Too little fluid in the body (dehydration)
- Diabetes that isn't being treated
- Taking too many water pills
- Drinking too much caffeine
- Taking medicines that make it hard to hold urine

When you talk to the doctor, be ready to answer the following questions:

- What medicines are the person with Alzheimer's taking?
- Does the person leak urine when he or she laughs, coughs, or lifts something?
- Does the person urinate often?
- Can the person get to the bathroom in time?
- Is the person urinating in places other than the bathroom?
- Is the person soiling his or her clothes or bed sheets each night?
- Do these problems happen each day or once in a while?

What To Do About Incontinence

Here are some ways you can deal with incontinence:

- Remind the person to go to the bathroom every 2 to 3 hours. Don't wait for him or her to ask.
- Show the person the way to the bathroom, or take him or her.
- Watch for signs that the person may have to go to the bathroom, such as restlessness or pulling at clothes. Respond quickly.
- Make sure that the person wears loose, comfortable clothing that is easy to remove.
- Limit fluids after 6 p.m. if problems happen at night. Do not give the person fluids with caffeine, such as coffee or tea.
- Give the person fresh fruit before bedtime instead of fluids if he or she is thirsty.

Here are some other tips:

- Mark the bathroom door with a big sign that reads "Toilet" or "Bathroom."
- Use a stable toilet seat that is at a good height. Using a colorful toilet seat may help the person identify the toilet. You can buy raised toilet seats at medical supply stores.
- Plan ahead if you are going out with the person. Know where restrooms are located. Take an extra set of clothing in case of an accident.
- Help the person when he or she needs to use a public bathroom. This may mean going into the stall with the person or using a family or private bathroom.

Accidents Happen

Be understanding when bathroom accidents occur. Stay calm and reassure the person if he or she is upset.

Incontinence supplies, such as adult disposable briefs or underwear, bed protectors, and waterproof mattress covers, may be helpful. You can buy these items at drugstores and medical supply stores.

A drainable pouch may be useful for the person who can't control his or her bowel movements. Talk to a nurse about how to use this product.

Some people find it helpful to keep a record of how much food and fluid the person with Alzheimer's takes in and how often he or she goes to the bathroom. You can use this information to make a schedule for going to the bathroom.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

Sundowning

Late afternoon and early evening can be difficult for some people with Alzheimer's disease. They may experience sundowning—restlessness, agitation, irritability, or confusion that can begin or worsen as daylight begins to fade—often just when tired caregivers need a break.

Sundowning can continue into the night, making it hard for people with Alzheimer's to fall asleep and stay in bed. As a result, they and their caregivers may have trouble getting enough sleep and functioning well during the day.

Possible Causes

The causes of sundowning are not well understood. One possibility is that Alzheimer's-related brain changes can affect a person's "biological clock," leading to confused sleep-wake cycles. This may result in agitation and other possible causes of sundowning including:

- being overly tired.
- unmet needs such as hunger or thirst.
- depression.
- pain.
- boredom.

Coping with Sundowning

Look for signs of sundowning in the late afternoon and early evening. These signs may include increased confusion or anxiety and behaviors such as pacing, wandering, or yelling. If you can, try to find the cause of the person's behavior.

If the person with Alzheimer's becomes agitated, listen calmly to his or her concerns and frustrations. Try to reassure the person that everything is OK and distract him or her from stressful or upsetting events.

You can also try these tips:

- Reduce noise, clutter, or the number of people in the room.
- Try to distract the person with a favorite snack, object, or activity. For example, offer a drink, suggest a simple task like folding towels, or turn on a familiar TV show (but not the news or other shows that might be upsetting).
- Make early evening a quiet time of day. You might play soothing music, read, or go for a walk. You could also have a family member or friend call during this time.

- Close the curtains or blinds at dusk to minimize shadows and the confusion they may cause. Turn on lights to help minimize shadows.

Preventing Sundowning

Being too tired can increase late afternoon and early evening restlessness. Try to avoid this situation by helping the person.

- Go outside or at least sit by the window—exposure to bright light can help reset the person's body clock.
- Get physical activity or exercise each day.
- Get daytime rest if needed, but keep naps short and not too late in the day.
- Get enough rest at night.
- Avoid things that seem to make sundowning worse:
- Do not serve coffee, cola, or other drinks with caffeine late in the day.
- Do not serve alcoholic drinks. They may add to confusion and anxiety.
- Do not plan too many activities during the day. A full schedule can be tiring.

If Problems Persist

If sundowning continues to be a problem, seek medical advice. A medical exam may identify the cause of sundowning, such as pain, a sleep disorder or other illness, or a medication side effect.

If medication is prescribed to help the person relax and sleep better at night, be sure to find out about possible side effects. Some medications can increase the chances of dizziness, falls, and confusion. Doctors recommend using them only for short periods of time.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
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Hallucinations, Delusions, Paranoia

As Alzheimer's disease progresses, the person with the disease may have hallucinations, delusions, or paranoia. During a **hallucination**, the person sees, hears, smells, tastes, or feels something that isn't there. He or she also may have **delusions**— false beliefs that the person thinks are real.

Paranoia is a type of delusion in which a person may believe—without a good reason— that others are mean, lying, unfair, or "out to get me." He or she may become suspicious, fearful, or jealous of people.

Hallucinations and Delusions

Here are some tips for coping with hallucinations and delusions:

- Tell the doctor or Alzheimer's disease specialist about the hallucinations or delusions.
- Discuss with the doctor any illnesses the person with Alzheimer's has and medicines he or she is taking. Sometimes an illness or medicine may cause hallucinations or delusions.
- Try not to argue with the person about what he or she sees or hears. Comfort the person if he or she is afraid.
- Distract the person. Sometimes moving to another room or going outside for a walk helps.
- Turn off the TV when violent or upsetting programs are on. Someone with Alzheimer's may think these events are happening in the room.
- Make sure the person is safe and can't reach anything that could be used to hurt anyone or him or herself.

Paranoia

In a person with Alzheimer's disease, paranoia is often linked to memory loss. It can become worse as memory loss gets worse.

For example, the person may become paranoid if he or she forgets:

- Where he or she put something. The person may believe that someone is taking his or her things. That you are the person's caregiver. Someone with Alzheimer's might not trust you if he or she thinks you are a stranger.
- People to whom the person has been introduced. He or she may believe that strangers will be harmful.
- Directions you just gave. The person may think you are trying to trick him or her.

Paranoia may be the person's way of expressing loss. The person may blame or accuse others because no other explanation seems to make sense.

Here are some tips for coping with paranoia:

- Try not to react if the person blames you for something.
- Don't argue with the person.
- Let the person know that he or she is safe.
- Use gentle touching or hugging to show you care.
- Explain to others that the person is acting this way because he or she has Alzheimer's disease.
- Search for things to distract the person, then talk about what you found. For example, talk about a photograph or keepsake.

Also, keep in mind that someone with Alzheimer's disease may have a good reason for acting a certain way. He or she may not be paranoid. There are people who take advantage of weak and elderly people. Find out if someone is trying to abuse or steal from the person with Alzheimer's

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
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Hallucinations

People with Alzheimer's or dementia can sometimes hear, see, smell, taste, or feel something that is not really there. They may talk to someone from the past who is no longer in the home or even still alive or is a pretend friend. This can alarm family and friends.

WHAT CAN YOU DO?

See a Doctor

- visit the doctor to find out the cause (bring ALL medications with you)
- tell the doctor about every time you think this has happened (keep a log — day, time, and what was going on around the person with Alzheimer's or dementia)

Think About the Cause

- change the possible reason
  - if the person doesn't know who is in the mirror, cover the mirror
  - if things come out in the dark, turn on the lights or use a nightlight
  - if the TV or radio is confusing or scary, turn it off

Be Reassuring

- say things like "don't worry, I'm here and will take care of you"
- agree, don't argue, about whether what's happening is real... it is real to them
- involve him or her in something pleasant to distract them

WHY DOES THIS HAPPEN?

People with Alzheimer's or dementia might be:

- **having a reaction to medicine**
- **taking the wrong amount of medicine**
- **going through changes in the brain due to the disease**

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Alucinaciones

Las alucinaciones es cuando una persona oye, ve, huele o saborea algo que no existe. Esta persona puede tener conversaciones que para él o ella son reales. El Alzheimer o demencia causa alucinaciones en algunas personas.

¿QUÉ PUEDE HACER?

Hable con el doctor

- lleve todas las medicinas a la visita con el doctor
- reporte los cambios de comportamiento, incluyendo cada cuándo y por cuanto tiempo sucede

Piense en lo que puede estar causando las alucinaciones

- cambie el ambiente
    - si la persona no se reconoce en el espejo, cubra el espejo con una sábana
    - si la persona ve cosas en la obscuridad, prenda la luz o use una luz de noche
    - si la televisión o la radio lo está confundiendo o asustando, apáguelo

Tranquilice a la persona con Alzheimer

- diga, "No se preocupe. Yo estoy aquí. Yo le ayudo."
- no discuta. Lo que la persona con Alzheimer ve o escucha es real para él
- trate de distraer a la persona con alguna actividad

¿POR QUÉ PASA ESTE PROBLEMA?

Personas con Alzheimer o demencia pueden:

- **tener una reacción a algún medicamento**
- **estar tomando su medicina incorrectamente**
- **estar pasando por cambios en el cerebro causados por el Alzheimer**

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Disinhibition (Intimacy & Sexuality)

Alzheimer's disease can cause changes in intimacy and sexuality in both a person with the disease and the caregiver. The person with Alzheimer's may be stressed by the changes in his or her memory and behaviors. Fear, worry, depression, anger, and low self-esteem (how much the person likes himself or herself) are common.

The person may become dependent and cling to you. He or she may not remember your life together and feelings toward one another. The person may even fall in love with someone else, or behave inappropriately toward you or others. It can be embarrassing for family members to watch their loved ones demonstrating inappropriate sexual behaviors, but it is important to remember that this is caused by the disease. The person is not behaving this way on purpose.

How to Cope with Changes in Intimacy

Most people with Alzheimer's disease need to feel that someone loves and cares about them. They also need to spend time with other people as well as you. Your efforts to take care of these needs can help the person with Alzheimer's to feel happy and safe. It's important to reassure the person that:

- you love him or her.
- you will keep him or her safe.
- others also care about him or her.

The following tips may help you cope with your own needs:

- Talk with a doctor, social worker, or clergy member about these changes. It may feel awkward to talk about such personal issues, but it can help.
- Talk about your concerns in a support group.
- Think more about the positive parts of the relationship.

Hypersexuality

Sometimes, people with Alzheimer's disease are overly interested in sex. This is called "hypersexuality." The person may masturbate a lot and try to seduce others. The person may remove his or her clothing in a public or inappropriate location. The person may also demonstrate inappropriate sexual behaviors toward others. These behaviors are symptoms of the disease and don't always mean that the person wants to have sex. To cope with hypersexuality, try giving the person more attention and reassurance. You might try:

- Gentle touch, hugging, or using other kinds of affection to meet his or her emotional needs.
- Not reacting with disapproval or anger. Remember that this is part of the disease and the person is not doing this on purpose.
- Don't try to reason with the person or explain that it is not appropriate behavior.
- Ignore the behaviors as much as possible, or lead the person to a private area.
- Be calm and reassuring when redirecting the person.
- Use a stalling tactic when needed, such as "We will be alone soon, but let's first go out for a walk."

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
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Coping with Agitation and Aggression

People with Alzheimer's disease may become agitated or aggressive as the disease gets worse. **Agitation** means that a person is restless or worried. He or she doesn't seem to be able to settle down. Agitation may cause pacing, sleeplessness, or **aggression**, which is when a person lashes out verbally or tries to hit or hurt someone.

Causes of Agitation and Aggression

Most of the time, agitation and aggression happen for a reason. When they happen, try to find the cause. If you deal with the causes, the behavior may stop. For example, the person may have:

- Pain, depression, or stress
- Too little rest or sleep
- Constipation
- Soiled underwear or diaper
- Sudden change in a well-known place, routine, or person
- A feeling of loss—for example, the person may miss the freedom to drive
- Too much noise or confusion or too many people in the room
- Being pushed by others to do something—for example, to bathe or to remember
- events or people—when Alzheimer's has made the activity very hard or impossible
- Feeling lonely and not having enough contact with other people
- Interaction of medicines

Look for early signs of agitation or aggression. If you see the signs, you can deal with the cause before problem behaviors start. Try not to ignore the problem. Doing nothing can make things worse.

A doctor may be able to help. He or she can give the person a medical exam to find any problems that may cause agitation and aggression. Also, ask the doctor if medicine is needed to prevent or reduce agitation or aggression.

Tips for Coping

Here are some ways you can cope with agitation or aggression:

- Reassure the person. Speak calmly. Listen to his or her concerns and frustrations. Try to show that you understand if the person is angry or fearful.
- Allow the person to keep as much control in his or her life as possible.
- Coping with changes is hard for someone with Alzheimer's. Try to keep a routine, such as bathing, dressing, and eating at the same time each day.
- Build quiet times into the day, along with activities.
- Keep well-loved objects and photographs around the house to help the person feel more secure.
- Try gentle touching, soothing music, reading, or walks.
- Reduce noise, clutter, or the number of people in the room.
- Try to distract the person with a favorite snack, object, or activity.
- Limit the amount of caffeine, sugar, and "junk food" the person drinks and eats.
- Here are some things you can do:
- Slow down and try to relax if you think your own worries may be affecting the person
- With Alzheimer's.
- Try to find a way to take a break from caregiving.

Safety Concerns

When the person is aggressive, protect yourself and others. If you must, stay at a safe distance from the person until the behavior stops. Also, try to protect the person from hurting himself or herself.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

Anger, Frustration & Fighting

People with Alzheimer's or dementia can get confused, depressed, and angry. Their feelings and actions are sometimes hard for them to control.

They may hit and yell.

Don't take their words or actions personally.

Listen to what they mean, not what they are saying.

WHAT CAN YOU DO?

Keep Things Simple

- try to match tasks and what you expect with what your person can do
- keep your home quiet and calm when you can
- speak slowly and try not to say too much at one time

Make a Change

- offer a treat like a cookie or some ice cream
- lead your person to a different room
- offer to watch a TV show or listen to music
- ask a question about a topic your person enjoys

Be Safe

- remove or lock away all weapons (guns, knives, etc.)
- back away slowly if the behavior is scary
- call 911 if you are afraid for your or someone else's safety

WHY DOES THIS HAPPEN?

People with Alzheimer's or dementia might:

- be confused by
  - new places or people
  - something they see and don't know
- become frustrated
  - because they can't pull on a sweater
  - open a door
  - find a lost item like a purse, wallet or glasses
- be frightened or scared of
  - the shower or bath
  - a new place or person

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Enojo, Peleas y Desesperación

Personas con Alzheimer o demencia se confunden fácilmente. También pueden enojarse, gritar y hasta pegar. No se ofenda por lo que digan o hagan. Trate de comprender lo que están tratando de decir.

¿QUÉ PUEDE HACER?

Mantenga las cosas sensillas

- mantenga el hogar tranquilo y calmado
- hable lentamente usando frases cortas y sencillas
- busque actividades que la persona con Alzheimer todavía pueda y quiera hacer

Haga un cambio

- háblele de un tema agradable
- llévelo a otro cuarto
- ofrézcale algo para comer como una fruta o un dulce
- mantenga la calma y trate de distraer a la persona con alguna actividad

Manténgase seguro

- ponga armas y cuchillos bajo llave
- si usted no se siente seguro, aléjese lentamente y pida ayuda
- si usted u otra persona están en peligro, llame al 9-1-1

¿POR QUÉ PASA ESTE PROBLEMA?

Personas con Alzheimer o demencia se frustra porque:

- **no pueden abrir la puerta**
- **no pueden vestirse**
- **no pueden encontrar algo que perdió como el bolso, la cartera o los lentes**
- **no reconocen donde están**
- **desconocen a sus familiares**

Persona con Alzheimer o demencia puede tener miedo

- **del baño o la ducha**
- **de una persona o un lugar nuevo**
- **de su propio reflejo**

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Effective Communication

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Communication and Alzheimer's

Communication is hard for people with Alzheimer's disease. They may struggle to find words, or forget what they want to say. They may no longer be able to use words at all, or to place them together into full sentences. You may feel impatient and wish they could just say what they want, but they can't.

The person with Alzheimer's may have problems with:

- Finding the right word or losing his or her train of thought when speaking.
- Understanding what words mean or how to use them together in a sentence.
- Paying attention during long conversations.
- Remembering the steps in common activities, such as cooking a meal, paying bills, or getting dressed.
- Blocking out background noises from the radio, TV, or conversations.
- Becoming frustrated if communication isn't working.
- Being very sensitive to touch and to the tone and loudness of voices.

Help Make Communication Easier

The first step is to understand that the disease causes changes in communication skills. The second step is to try some tips that may make communication easier:

- Make eye contact and call the person by name.
- Be aware of your tone, how loud your voice is, how you look at the person, and your body language.
- Encourage a two-way conversation for as long as possible.
- Use other methods of communication besides speaking, such as gentle touch and body language (gestures, eye contact, tone of voice, etc.).
- Try distracting the person if communication creates problems.
- To encourage the person to communicate with you:
- Show a warm, loving, matter-of-fact manner.

- Hold the person’s hand while you talk. Be open to the person’s concerns, even if he or she is hard to understand.
- Let him or her make some decisions and stay involved.
- Be patient with angry outbursts. Remember, it’s the illness “talking.”

To speak effectively with a person who has Alzheimer’s:

- Offer simple, step-by-step instructions.
- Repeat instructions and allow more time for a response. Try not to interrupt.
- Don’t talk about the person as if he or she isn’t there.
- Don’t talk to the person using “baby talk” or a “baby voice.”

Be Direct, Specific, and Positive

Here are some examples of what you can say:

- “Let’s try this way,” instead of pointing out mistakes.
- “Please do this,” instead of “Don’t do this.”
- “Thanks for helping,” even if the results aren’t perfect.

You also can:

- Ask questions that require a yes or no answer.   For example, you could say, “Are you tired?” instead of “How do you feel?”
- Limit the number of choices.   For example, you could say, “Would you like a hamburger or chicken for dinner?” instead of “What would you like for dinner?”
- Use different words if he or she doesn’t understand the first time. For example, if you ask the person whether he or she is hungry and you don’t get a response, you could say, “Dinner is ready now. Let’s eat.”
- Try not to say, “Don’t you remember?” or “I told you.” If you become frustrated, take a timeout for yourself.

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Home Safety Assessment

General Home Safety

☐ Do not leave care recipient home alone.

☐ Make sure car keys are well hidden.

☐ Weapons, such as firearms, should always be unloaded and put in a locked cabinet.

☐ Post emergency numbers on or near telephones.

Securing Exits & Entrances

☐ Doors leading to exits should be locked.

☐ Lock sliding glass doors (use a wooden dowel in the runner at the bottom of the door).

☐ Doors leading to unsafe areas (i.e. pool, garage, closets where dangerous items are stored) should be locked.

☐ Windows and balcony doors should be secured.

☐ For doors that lock from the inside, remove the lock or keep an emergency key in a nearby, secure location.

☐ Give a spare key to a trusted neighbor, family member, or friend for emergencies or store an extra key in a secure, hidden location.

Wandering

☐ Get identification bracelet for care recipient (Alzheimer's Greater Los Angeles MedicAlert® Found California program provides an identification bracelet and registry).

Fall/Trip Hazards

☐ Clear walkways and staircases from trip hazards like electrical cords, books, toys, and trash.

☐ Remove throw rugs to reduce the risk of falls or trips.

☐ Remove or secure furniture that rolls, falls over easily, or cannot support a person's weight.

☐ Use nightlights in the bathroom, hallway, and bedroom.

☐ Increase brightness of lamps and fixtures.

Fire/Burn Hazards

☐ Have a working fire extinguisher.

☐ Install smoke detectors and carbon monoxide detectors.

☐ The thermostat on the hot water heater should be lowered to its lowest setting or no higher than 120 degrees Fahrenheit.

☐ Replace extension cords with surge protections.

Kitchen Safety

☐ Remove the knobs from the stove and oven or use knob covers to hide the knobs.

☐ Remove knives and scissors from counters and keep out of reach.

☐ Secure all cleaning supplies.

☐ Disable the garbage disposal and instant hot water.

☐ Unplug all electrical appliances when they are not being used.

☐ Products that can be eaten in excess and cause illness (i.e. sweeteners) should be placed out of reach.

Bathroom Safety

☐ Store medications, including vitamins and over-the-counter medications, in a locked cabinet or out of reach.

☐ Toxic products and products that can be eaten in excess and cause illness (i.e. toothpaste) should be placed out of reach.

☐ Remove razors and other sharp objects from counters and drawers; keep them out of reach.

☐ Use non-skid mats in the shower and tub.

☐ Install grab bars or safety rails in shower/tub.

☐ Install a toilet safety rail.

☐ Use a shower bench (for stability) in the shower/tub.

☐ Remove and hide personal electrical equipment such as hair dryers and curling irons.

The Home Safety Assessment is not all-inclusive, nor do the suggestions in the Assessment substitute for close supervision, at all times, of a person with memory loss.

Safety Concerns

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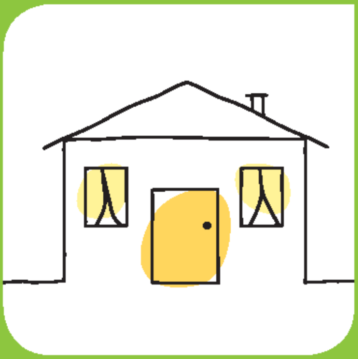

WHY DOES THIS HAPPEN?

People with Alzheimer's or dementia might:

- **trip because of changes in balance or trouble walking**
- **have problems seeing clearly due to poor eyesight**
- **forget to turn off water, burners, ovens**
- **forget how to use knives, etc. or where to safely place burning objects**

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Keeping Home Safe

People with Alzheimer's or dementia may have trouble knowing what is dangerous or making safe decisions. By helping him or her feel more relaxed and less confused at home, you can help stop accidents.

WHAT CAN YOU DO?

Keep Things Simple

- make sure rooms are neat
- place "often used" items in the same place
- remove things that might break and aren't needed

Look at the Floor

- remove small rugs, rugs that are thick, or rugs that might slide on floors
- don't shine or wax floors
- keep items off floors... cords, books, toys, bags, boxes, etc.
- make sure bathroom and kitchen floors are kept dry and avoid walking with wet feet
- use tables and chairs that are stable enough to lean on

Remove Dangerous Items

- keep all medicines... vitamins, aspirin, prescriptions... in a locked box, cabinet, or drawer
- place knives, scissors, guns, sharp tools, matches, and lighters out of sight or in a locked area
- move all cleaning supplies to a high shelf or lock them away
- take off knobs from the stove and oven

Don't Leave Him or Her Alone

- in the kitchen with the stove or oven on
- in the bathroom with water running
- anywhere with burning cigarettes, cigars, or pipes
- near an open or unlocked door or gate

Seguridad en el Hogar

Personas con Alzheimer o demencia a veces no pueden entender lo que ven. Por ejemplo, los escalones pueden verse planos o las alfombras negras pueden parecer hoyos. También pueden tener problemas para entender situaciones peligrosas o tomar decisiones seguras. Para evitar estas situaciones, le ayudaría si usted hace algunos cambios al hogar.

¿QUÉ PUEDE HACER?

Evite el desorden

- mantenga los cuartos cómodos
- mantenga los artículos de uso diario en el mismo lugar
- guarde las cosas frágiles que estén al alcance, tales como: vidrios, espejos y vajillas

Revise el piso

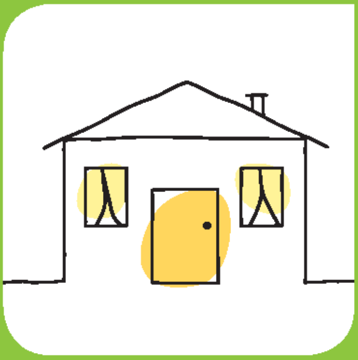
- quite alfombras pequeñas que puedan causar tropiezos
- no deje cables electrónicos, libros, juguetes o basura en el piso
- asegúrese que el piso del baño y la cocina no estén resbalosos
- asegúrese que las sillas y mesas sean lo suficientemente estables como para apoyarse en ellas

Guarde objetos que puedan ser peligrosos

- mantenga TODOS los medicamentos (incluyendo vitaminas) bajo llave o fuera del alcance
- mantenga herramientas filosas fuera de la vista o bajo llave, tales como: cerillos, cuchillos y pistolas
- guarde bajo llave todos los productos de limpieza, tales como: amonia, windex, jabón y detergentes
- quite los apagadores de la estufa y horno, y desenchufe aparatos electrónicos

No deje a la persona con Alzheimer sola

- en la cocina con el horno o estufa encendida
- en el baño con el agua corriendo
- con cigarrillos o un puro prendido
- con la puerta abierta o sin seguro



¿POR QUÉ PASA ESTE PROBLEMA?

Personas con Alzheimer o demencia pueden:

- tropezarse por cambios de balance y el equilibrio
- tener cambios de la vista
- olvidan de apagar el agua, la estufa, hornos
- olivdan cómo usar objetos que pueden ser peligrosos (armas, cuchillos, etc.) de forma segura

Alzheimer's GREATER LOS ANGELES
...including the Inland Empire & south Ventura County

24/7 Helpline
844.HELP.ALZ
alzgla.org

Supported by DHHS, ACL (#90AL0002-01-00)

Wandering

Many people with Alzheimer's disease wander away from their home or caregiver. As the caregiver, you need to know how to limit wandering and prevent the person from becoming lost. This will help keep the person safe and give you greater peace of mind.

First Steps

Try to follow these steps before the person with Alzheimer's disease wanders:

- Make sure the person carries some kind of ID or wears a medical bracelet. If the person gets lost and can't communicate clearly, an ID will let others know about his or her illness. It also shows where the person lives.
- Consider enrolling the person in the MedicAlert® Found California Program (call 1.844.435.7259 to find out more information).
- Let neighbors and the local police know that the person with Alzheimer's tends to wander. Ask them to alert you immediately if the person is seen alone and on the move.
- Place labels in garments to aid in identification.
- Keep an article of the person's worn, unwashed clothing in a plastic bag to aid in finding him or her with the use of dogs.
- Keep a recent photograph or video recording of the person to help police if he or she becomes lost.

Tips to Prevent Wandering

Here are some tips to help prevent the person with Alzheimer's from wandering away from home:

- Keep doors locked. Consider a keyed deadbolt, or add another lock placed up high or down low on the door. If the person can open a lock, you may need to get a new latch or lock.
- Use loosely fitting doorknob covers so that the cover turns instead of the actual knob

- Place STOP, DO NOT ENTER, or CLOSED signs on doors.
- Divert the attention of the person with Alzheimer's disease away from using the door by placing small scenic posters on the door; placing removable gates, curtains, or brightly colored streamers across the door; or wallpapering the door to match any adjoining walls.
- Install safety devices found in hardware stores to limit how much windows can be opened.
- Install an "announcing system" that chimes when the door opens.
- Secure the yard with fencing and a locked gate.
- Keep shoes, keys, suitcases, coats, hats, and other signs of departure out of sight.
- Do not leave a person with Alzheimer's who has a history of wandering unattended.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

MedicAlert® Found California Program

MedicAlert® is a 24-hour nationwide emergency response service for individuals with Alzheimer's or a related dementia who wander or have a medical emergency. We provide 24-hour assistance, no matter when or where the person is reported missing.

How it works:

Report a wandering incident:

- Call 911
- Then call 800.625.3780,
  MedicAlert® emergency response line

If an individual with Alzheimer's or a related dementia wanders and becomes lost, caregivers can call the 24-hour emergency response line (1.800.625.3780) to report it.

A community support network will be activated, including local Alzheimer's organizations and law enforcement agencies, to help reunite the person who wandered with the caregiver or a family member. With this service, critical medical information will be provided to emergency responders when needed.

If a citizen or emergency personnel finds the person with dementia, they can call the toll-free number listed on the person's MedicAlert® ID jewelry.

MedicAlert® will notify the listed contacts, making sure the person is returned home.

Cost and ID jewelry

MedicAlert® provides an ID bracelet or pendant to be worn by the individual with dementia.

For more information on this program, please contact Alzheimer's Greater Los Angeles at 888.HELP.ALZ | 888.435.7259.

For information about medicines to treat Alzheimer's disease, see the "Alzheimer's Disease Medications Fact Sheet," *www.nia.nih.gov/alzheimers/publication/alzheimers-disease-medications-fact-sheet.*

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

WHY DOES THIS HAPPEN?

People with Alzheimer's or dementia might:

- **be confused… mainly in the afternoon or evening**
- **feel fearful … home may not seem the same**
- **try to go somewhere they used to go often… work, church, etc.**
- **attempt to get away from noise or too much activity**
- **be bored – not having anything to do**
- **have a reaction to a new medicine**

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Getting Lost

People with Alzheimer's disease or dementia can get lost outside of their home. Sometimes they wander away in a public place. They may go for a walk or to the store and not be able to find their way home. They may not remember their address or phone number.

Getting lost is scary and can be dangerous.

WHAT CAN YOU DO?

Be Prepared

- get a MedicAlert® bracelet for your person with dementia
- sew or write his or her name and your phone number onto clothes
- don't leave him or her alone near an unlocked door
- ask your neighbors to keep an eye out and to tell you if they see your person with dementia outside alone or walking away from home
- help him or her exercise during the day… take a walk or dance to music
- put away purses, coats, keys, sunglasses… things that might make your person think about leaving
- close the curtains so he or she doesn't think about going outside

Make Home a Safe Place

- put child-proof locks on doors, gates, and windows
- place locks very high or low so your person with dementia can't see or reach the locks
- place a bell on doors, gates, or windows so you know if they are opened

Be Comforting

- offer food or do something that will take his or her mind off wanting to leave
- ask for help… folding clothes, making dinner, etc.
- sit quietly with him or her… listen to music or watch a TV show

Perderse

Algunas personas con Alzheimer o demencia se pueden perder al salir de casa. Estas personas se pierden fácilmente y olvidan el camino de regreso a casa, su dirección o número de teléfono. Perderse puede ser peligroso para la persona con Alzheimer.

¿QUÉ PUEDE HACER?

Esté preparado

- obtenga un brazalete/pulsera de MedicAlert®
- cosa o escriba el nombre de la persona con Alzheimer y un número de emergencia en la ropa
- no deje a la persona con Alzheimer sóla o cerca de una puerta que no tenga seguro
- pídale a sus vecinos que le avisen si la persona con Alzheimer se sale a la calle
- si es posible, saque a la persona con Alzheimer a caminar o hagan algún tipo de ejercicio en casa
- guarde monederos, llaves y abrigos que puedan causar que la persona con Alzheimer quiera salir de casa

Mantenga el hogar seguro

- instale seguros en puertas y ventanas
- coloque los seguros en puertas y ventanas fuera del alcance de la persona con Alzheimer
- instale una campanita en la puerta para que suene cuándo se abra

Si la persona con Alzheimer se encuentra nerviosa

- trátela con cariño, y dígale “No se preocupe. Yo estoy aquí. Yo le ayudo.”
- ofrézcale algo de comer o hagan alguna actividad que le guste para distraerlo
- pídale que le ayude a doblar la ropa o preparar la cena
- siéntese en silencio con la persona con Alzheimer o escuche música agradable

¿POR QUÉ PASA ESTE PROBLEMA?

Personas con Alzheimer o demencia pueden:

- **confundirse especialmente por la tarde y por la noche**
- **tener una reacción a un medicamento nuevo**
- **tener miedo–se sienten inseguros al no reconocer donde están**
- **pueden tratar de ir a trabajar o hacer algo que hacían antes**
- **estar tratando de escapar del ruido o de la actividad en el cuarto**
- **estár aburridos**
- **sentir algún malestar**
- **tener hambre, frío o necesidad de usar el baño**

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Driving

Good drivers are alert, think clearly, and make good decisions. When a person with Alzheimer's disease is not able to do these things, he or she should stop driving. But, he or she may not want to stop driving or even think there is a problem.

As the caregiver, you will need to talk with the person about the need to stop driving. Do this in a caring way. Understand how unhappy the person may be to admit that he or she has reached this new stage.

Safety First

A person with some memory loss may be able to drive safely sometimes. But, he or she may not be able to react quickly when faced with a surprise on the road. Someone could get hurt or killed. If the person's reaction time slows, you need to stop the person from driving.

Here are some other things to know about driving and memory loss:

- The person may be able to drive short distances on local streets during the day but may not be able to drive safely at night or on a freeway. If this is the case, then limit the times and places the person can drive.
- Some people with memory problems decide on their own not to drive, while others may deny they have a problem.

Signs that the person should stop driving include new dents and scratches on the car. You may also notice that the person takes a long time to do a simple errand and cannot explain why, which may indicate that he or she got lost.

When Driving Becomes Unsafe

Here are some ways to stop people with Alzheimer's disease from driving:

- Try talking about your concerns with the person.
- Take him or her to get a driving test.
- Ask your doctor to tell him or her to stop driving. The doctor can write, "Do not drive" on a prescription pad, and you can show this to the person.
- Hide the car keys, move the car, take out the distributor cap, or disconnect the battery.

There are other ways to get around:

- Ask family or friends to drive the person.
- Find out about services that help people with disabilities get around their community. These services may include free or low-cost buses, taxi service, and carpools. Contact your local Area Agency on Aging or call the Community Transportation Association at 1-800-527-8279.

If the person with Alzheimer's disease won't stop driving, ask your state Department of Motor Vehicles about a medical review. The person may be asked to retake a driving test. In some cases, the person's license could be taken away. (California DMV office: 800-777-0133)

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

Dementia & Driving

WHAT HEALTHCARE PROFESSIONALS NEED TO KNOW

In the State of California, physicians and surgeons are required to report any patient with a disorder characterized by lapses of consciousness. This includes Alzheimer's disease and dementia.

By law, they must report drivers who have medical conditions or functional impairments that may affect safe driving ability. Reports must be made immediately to the local health officer, in writing. Reports must include the name of the patient, date of birth, and address (Health and Safety Code Section 103900).

The California Department of Public Health has a reporting form called the **Confidential Morbidity Report (CMR)** which helps facilitate the reporting process and fulfills mandatory reporting obligations. It is available online at *http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph110c.pdf*. Once the CMR is completed, it must be returned to the patient's local health officer.

For Additional Information

To locate your patient's local health officer, go to the California Health Officers Directory:

http://www.cdph.ca.gov/programs/cclho/Documents/CCLHOHealthOfficerDirectory.pdf

Alzheimer's Greater Los Angeles can provide information, emotional support, caregiving tools, and referrals for people with dementia, their families, and healthcare professionals.

EFFECTIVE COMMUNICATION WITH YOUR PATIENT ABOUT LOSS OF DRIVING PRIVILEGES

- Be EMPATHETIC. For many people, loss of driving can mean loss of independence.
- Reinforce MEDICAL DIAGNOSIS and importance of SAFETY.
- Stress the POSITIVES and offer ALTERNATIVES.
- Appeal to your patient's sense of RESPONSIBILITY.
- Reaffirm SUPPORT.
- Refer patient and family to the Alzheimer's Greater Los Angeles for additional information and support.

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State of California—Health and Human Services Agency

California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address

Primary Language ☐ English ☐ Spanish ☐ Other: ____________

Birth Date *(mm/dd/yyyy)*

Age ☐ Years ☐ Months ☐ Days

Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: ____________

Pregnant? ☐ Yes ☐ No ☐ Unknown

Est. Delivery Date *(mm/dd/yyyy)*

Country of Birth

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
- ☐ African-American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian *(check all that apply)*
  - ☐ Asian Indian
  - ☐ Cambodian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Hmong
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ Thai
  - ☐ Vietnamese
  - ☐ Other *(specify)*: ____________
- ☐ Pacific Islander *(check all that apply)*
  - ☐ Native Hawaiian
  - ☐ Guamanian
  - ☐ Samoan
  - ☐ Other *(specify)*: ________
- ☐ White
- ☐ Other *(specify)*: ______________
- ☐ Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: ______________________________

Date of Onset *(mm/dd/yyyy)* | ***Date of First Specimen Collection*** *(mm/dd/yyyy)* | ***Date of Diagnosis*** *(mm/dd/yyyy)* | ***Date of Death*** *(mm/dd/yyyy)*

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Submitted by | ***Date Submitted*** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners
(check all that apply)
☐ Male ☐ Female ☐ Unknown ☐ M to F Transgender ☐ F to M Transgender ☐ Other: __________

STD TREATMENT ☐ Treated in office ☐ Given prescription

Drug(s), Dosage, Route ____________________________________

Treatment Began *(mm/dd/yyyy)* ____________

☐ ***Untreated***
- ☐ Will treat
- ☐ Unable to contact patient
- ☐ Patient refused treatment
- ☐ Referred to: ____________

If reporting Syphilis, Stage:
- ☐ Primary (lesion present)
- ☐ Secondary
- ☐ Early latent < 1 year
- ☐ Latent (unknown duration)
- ☐ Late latent > 1 year
- ☐ Late (tertiary)
- ☐ Congenital

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results			**Titer**
☐ RPR	☐ Pos	☐ Neg	_____
☐ VDRL	☐ Pos	☐ Neg	_____
☐ FTA-ABS	☐ Pos	☐ Neg	
☐ TP-PA	☐ Pos	☐ Neg	
☐ EIA/CLIA	☐ Pos	☐ Neg	
☐ CSF-VDRL	☐ Pos	☐ Neg	_____
☐ Other: ______________			

If reporting Chlamydia and/or Gonorrhea:

Specimen Source(s)
(check all that apply)
- ☐ Cervical
- ☐ Pharyngeal
- ☐ Rectal
- ☐ Urethral
- ☐ Urine
- ☐ Vaginal
- ☐ Other: ________

Symptoms? ☐ Yes ☐ No ☐ Unknown

If reporting Pelvic Inflammatory Disease:
(check all that apply)
- ☐ Gonococcal PID
- ☐ Chlamydial PID
- ☐ Other/Unknown Etiology PID

Partner(s) Treated?
- ☐ Yes, treated in this clinic
- ☐ Yes, Meds/Prescription given to patient for their partner(s)
- ☐ Yes, other: ____________
- ☐ No, instructed patient to refer partner(s) for treatment
- ☐ No, referred partner(s) to: ____________
- ☐ Unknown

VIRAL HEPATITIS

Diagnosis (check all that apply)
- ☐ Hepatitis A
- ☐ Hepatitis B (acute)
- ☐ Hepatitis B (chronic)
- ☐ Hepatitis B (perinatal)
- ☐ Hepatitis C (acute)
- ☐ Hepatitis C (chronic)
- ☐ Hepatitis D
- ☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
- ☐ Blood transfusion, dental or medical procedure
- ☐ IV drug use
- ☐ Other needle exposure
- ☐ Sexual contact
- ☐ Household contact
- ☐ Perinatal
- ☐ Child care
- ☐ Other: ______________

ALT (SGPT)
Result: _____ Upper Limit: _____

AST (SGOT)
Result: _____ Upper Limit: _____

Bilirubin result: __________

		Pos	**Neg**
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: __________		

		Pos	**Neg**
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

☎ ! = Report immediately by telephone (designated by a ♦ in regulations).

† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a • in regulations.)

☎ = Report by telephone within one working day of identification (designated by a + in regulations).

FAX ☎ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).

= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

FAX ☎ ✉	Amebiasis
	Anaplasmosis
☎ !	Anthrax, human or animal
FAX ☎ ✉	Babesiosis
☎ !	Botulism (Infant, Foodborne, Wound, Other)
	Brucellosis, animal (except infections due to *Brucella canis*)
☎ !	Brucellosis, human
FAX ☎ ✉	Campylobacteriosis
	Chancroid
FAX ☎ ✉	Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
FAX ☎ ✉	Chikungunya Virus Infection
	Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
☎ !	Cholera
☎ !	Ciguatera Fish Poisoning
	Coccidioidomycosis
	Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ☎ ✉	Cryptosporidiosis
	Cyclosporiasis
	Cysticercosis or taeniasis
☎ !	Dengue Virus Infection
☎ !	Diphtheria
☎ !	Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
	Ehrlichiosis
FAX ☎ ✉	Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
☎ !	*Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
☎ !	Flavivirus infection of undetermined species
† FAX ☎ ✉	Foodborne Disease
	Giardiasis
	Gonococcal Infections
FAX ☎ ✉	*Haemophilus influenzae*, invasive disease, all serotypes (report an incident of less than five years of age)
FAX ☎ ✉	Hantavirus Infections
☎ !	Hemolytic Uremic Syndrome
FAX ☎ ✉	Hepatitis A, acute infection
	Hepatitis B (specify acute case or chronic)
	Hepatitis C (specify acute case or chronic)
	Hepatitis D (Delta) (specify acute case or chronic)
	Hepatitis E, acute infection
	Human Immunodeficiency Virus (HIV) infection, stage 3 (AIDS)
☎	Human Immunodeficiency Virus (HIV), acute infection
	Influenza, deaths in laboratory-confirmed cases for age 0-64 years
☎ !	Influenza, novel strains (human)
	Legionellosis
	Leprosy (Hansen Disease)
	Leptospirosis

FAX ☎ ✉	Listeriosis
	Lyme Disease
FAX ☎ ✉	Malaria
☎ !	Measles (Rubeola)
FAX ☎ ✉	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
☎ !	Meningococcal Infections
	Mumps
☎ !	Novel Virus Infection with Pandemic Potential
☎ !	Paralytic Shellfish Poisoning
FAX ☎ ✉	Pertussis (Whooping Cough)
☎ !	Plague, human or animal
FAX ☎ ✉	Poliovirus Infection
FAX ☎ ✉	Psittacosis
FAX ☎ ✉	Q Fever
☎ !	Rabies, human or animal
FAX ☎ ✉	Relapsing Fever
	Respiratory Syncytial Virus (only report a death in a patient less than less than five years of age)
	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
	Rocky Mountain Spotted Fever
	Rubella (German Measles)
	Rubella Syndrome, Congenital
FAX ☎ ✉	Salmonellosis (Other than Typhoid Fever)
☎ !	Scombroid Fish Poisoning
☎ !	Shiga toxin (detected in feces)
FAX ☎ ✉	Shigellosis
☎ !	Smallpox (Variola)
FAX ☎ ✉	Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ☎ ✉	Syphilis
	Tetanus
FAX ☎ ✉	Trichinosis
FAX ☎ ✉	Tuberculosis
	Tularemia, animal
☎ !	Tularemia, human
FAX ☎ ✉	Typhoid Fever, Cases and Carriers
FAX ☎ ✉	*Vibrio* Infections
☎ !	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ☎ ✉	West Nile Virus (WNV) Infection
☎ !	Yellow Fever
FAX ☎ ✉	Yersiniosis
☎ !	Zika Virus Infection
☎ !	OCCURRENCE of ANY UNUSUAL DISEASE
☎ !	OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20

Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/tOAHIVRptgSP.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)

Pesticide-related illness or injury (known or suspected cases)**

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

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* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

Managing Medications

People with Alzheimer's disease may take medicines to treat the disease itself, mood or behavior changes, and other medical conditions. Caregivers can ensure that medicines are taken safely and correctly.

Learn the Basics

Know **each** medicine (prescription and over-the-counter) the person with Alzheimer's disease takes. Ask the doctor or pharmacist:

- Why is this medicine being used?
- What positive effects should I look for, and when?
- What are the possible side effects, and what can I do about them?
- Can this medicine cause a problem if it is taken with other medicines?
- How long will the person need to take it?
- How much should he or she take each day?
- When does the person need to take the medicine?
- What if the person misses a dose?

Managing medications is easier if you have a complete list of them. The list should show the name of the medicine, the doctor who prescribed it, how much the person with Alzheimer's takes, and how often. Keep the list in a safe place at home, and make a copy to keep in your purse or wallet. Bring it with you when you visit the person's doctor or pharmacist.

People with Alzheimer's should be monitored when a new drug is started. Follow the doctor's instructions and report any unusual symptoms right away. Also, let the doctor know before adding or changing any medications.

Use Medicines Safely

People with Alzheimer's disease often need help taking their medicine. If the person lives alone, you may need to call and remind him or her or leave notes around the home. A pillbox allows you to put pills for each day in one place. Some pillboxes come with alarms that remind a person to take medicine. As Alzheimer's gets worse, you will need to keep track of the person's medicines. You also will need to make sure the person takes the medicines or give the medicines to him or her.

Some people with Alzheimer's take medicines to treat behavior problems such as restlessness, anxiety, depression, trouble sleeping, and aggression. Experts agree that medicines to treat behavior problems should be used only after other strategies that don't use medicine have been tried. Talk with the person's doctor about which medicines are safest and most effective. With these types of medicines, it is important to:

- Use the lowest dose possible.
- Watch for side effects such as confusion and falls.
- Allow the medicine a few weeks to take effect.

People with Alzheimer's should NOT take anticholinergic drugs. These drugs are used to treat many medical problems, such as sleeping problems, stomach cramps, incontinence, asthma, motion sickness, and muscle spasms. Side effects can be serious for a person with Alzheimer's. Talk with the person's doctor about other, safer drugs.

Other Safety Tips

Some people, especially those with late-stage Alzheimer's, may have trouble swallowing pills. In this case, ask the pharmacist if the medicine can be crushed or taken in liquid form. Other ways to make sure medicines are taken safely:

- Keep all medications locked up.
- Check that the label on each prescription bottle has the drug name and dose, patient's name, dosage frequency, and expiration date.
- Call the doctor or pharmacist if you have questions about any medicine.

For information about medicines to treat Alzheimer's disease, see the "Alzheimer's Disease Medications Fact Sheet," *www.nia.nih.gov/alzheimers/publication/alzheimers-disease-medications-fact-sheet.*

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

Medications

People with Alzheimer's or dementia may need help with taking their medicine. Taking too much... or too little... or not following the directions... can be dangerous.

WHAT CAN YOU DO?

Watch Closely

- make sure he or she
    - takes the right number of pills at the right times
    - follows the directions on the medication
- do not leave medications in a pill box or cup on the counter
- do not leave him or her alone to take their medicine

Lock Away Medicine

- make sure all medications are out of sight and out of reach

Talk to ALL the Doctors

- do not stop giving any medicine without asking the prescribing doctor first
- bring all medicines in a bag or box to every doctor
    - include vitamins, herbs, teas, creams, and other pills from the drugstore
- ask the doctor if medicines can be mixed into foods or drinks
    - this is helpful if you are having trouble getting your person to take their pills

NOTE: If you notice sudden changes like violent behaviors or trouble with bathroom accidents, call the doctor.

- these changes could be caused by a reaction to a medication or a new illness

WHY DOES THIS HAPPEN?

People with Alzheimer's or dementia might:

- forget to take their medications
- forget that they took their medication, so they take them again and again and again
- get sick or be poisoned because the wrong pills or too many pills were taken

Alzheimer's
GREATER LOS ANGELES
...including the Inland Empire & south Ventura County

24/7 Helpline
844.HELP.ALZ
alzgla.org

Supported by DHHS, ACL (#90AL0002-01-00)

Medicamentos

Personas con Alzheimer o demencia necesitan ayuda para tomar sus medicinas de una manera segura. Puede ser peligroso si toman demasiada o poca medicina, o no siguen las instrucciones correctamente.

¿QUÉ PUEDE HACER?

Vigile que la persona con Alzheimer esté:

- tomando la medicina correctamente
    - a la hora que debe
    - el número exacto de pastillas
- siguiendo las instrucciones del doctor
- tomando sus pastillas con agua antes o después de la comida (algunas medicinas no se deben tomar con jugos cítricos, tales como: naranja, limón, toronja y mandarina)
- no piense que la persona con Alzheimer se tomará la medicina correctamente sin ayuda

Siempre guarde la medicina fuera de la vista y del alcance de la persona con Alzheimer

- guarde todos los medicamentos bajo llave o fuera de la vista

Hable con TODOS los doctores que atienden a la persona con Alzheimer

- no le de pastillas de otras personas
- hable con su doctor antes de dar vitaminas, remedios caseros u otras pastillas a la persona con Alzheimer
- no pare de dar la medicina sin primero hablar con el doctor
- lleve las vitaminas, tés, cremas o pastillas que usted ha comprado sin receta a las citas con el doctor

NOTA: Si usted ve cambios fuera de lo normal como agresividad o la persona se hace del baño accidentalmente, llame a su doctor

- el cambio puede ser causado por una infección o reacción a los medicamentos

¿POR QUÉ PASA ESTE PROBLEMA?

Personas con Alzheimer o demencia pueden:

- olvidarse de tomar sus medicamentos
- olvidar de que ya se tomaron sus medicinas y se las vuelven a tomar
- tomarse los medicamentos incorrectamente y enfermarse o hasta envenenarse

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Elder Abuse

Alzheimer's
GREATER LOS ANGELES

Elder Abuse & Dementia

WHAT HEALTHCARE PROFESSIONALS NEED TO KNOW

Why is it URGENT that Healthcare Professionals Report Elder Abuse?

- As many as 1 in 10 older adults, and ***1 in 2 people with dementia, are victims of elder abuse.***
- For every case of elder abuse that gets reported, there are ***23.5 that go unreported.***
- 70 - 90% of perpetrators of elder abuse are family members, loved ones, or caregivers.

[See Ageless Alliance at *http://agelessalliance.org for more info*]

Why are People with Dementia Particularly Vulnerable to Abuse?

Abuse can occur anywhere, including at home and in care settings. People with dementia are especially vulnerable because the disease may prevent them from reporting the abuse or recognizing it. They also may fall prey to people, including strangers, who take advantage of their cognitive impairment.

Psychoses, such as paranoia, delusions, or hallucinations, can make caregiving challenging, and even contribute to neglect and self-neglect. When families receive support services, they are more likely to effectively cope with difficult situations.

[See Alzheimer's Association at *http://www.alz.org/care/alzheimers-dementiaelder-abuse.asp#ixzz2uv9DrWh1* for more information.]

Reporting Elder Abuse

Health practitioners are mandated reporters of elder abuse. Health practitioners must file a report if they have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse Self-neglect can include deficits in physical self-care, medical care, health and safety hazards, and/or malnutrition.

[Welfare and Institutions Code Section 15630-15632. See *http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=15001-16000&file=15630-15632* for more information.

For Additional Information

Contact your local Adult Protective Services (APS) County Reporting Hotline.

SPOTLIGHT ON SELF-NEGLECT

- **People with dementia may lack insight or the ability to utilize sound judgment to care for themselves and assess safety issues such as falls or wandering. They may also refuse medical care, thus triggering a selfneglect concern.**
- **Neglect can include lack of appropriate supervision as well as basic needs not being met.**
- **People with dementia need supervision and guidance so they are safe and adequately provided for.**

Alzheimer's GREATER LOS ANGELES

...including the Inland Empire & south Ventura County

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STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information (Ombudsman use only - WIC 15636(a))

NAME (LAST NAME, FIRST NAME)	AGE	DATE OF BIRTH

SSN	GENDER ☐ M ☐ F	ETHNICITY	LANGUAGE (✔ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (*SPECIFY*)

ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)	CITY	ZIP CODE	TELEPHONE ( )
PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	CITY	ZIP CODE	TELEPHONE ( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED

☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER

☐ LIVES ALONE

☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER *✔ Check if ☐ Self-Neglect*

NAME OF SUSPECTED ABUSER

ADDRESS	CITY	ZIP CODE	TELEPHONE ( )

☐ CARE CUSTODIAN (type) ________________ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER____________________

☐ HEALTH PRACTITIONER (type) __________ ☐ SPOUSE ☐ OTHER RELATION______________________________

GENDER ☐ M ☐ F	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR

C. REPORTING PARTY *Check appropriate box if reporting party waives confidentiality to:* ☐ ✔ All ☐ ✔ All but victim ☐ ✔ All but perpetrator

NAME	SIGNATURE	OCCUPATION	AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW ABUSE IS KNOWN	STREET	CITY	ZIP CODE	TELEPHONE ( )

E-MAIL ADDRESS

D. INCIDENT INFORMATION - Address where incident occurred

DATE/TIME OF INCIDENT(S)	PLACE OF INCIDENT (✔ CHECK ONE) ☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL ☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✔ CHECK ALL THAT APPLY)

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. ☐ PHYSICAL (e.g. assault/battery, constraint or deprivation, chemical restraint, over/under medication)

d. ☐ NEGLECT (including Deprivation of Goods and Services by a Care Custodian

b. ☐ SEXUAL

e. ☐ ABANDONMENT

g. ☐ ABDUCTION

i. ☐ OTHER ____

c. ☐ FINANCIAL

f. ☐ ISOLATION

h. ☐ PSYCHOLOGICAL/MENTAL

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g. personal hygiene, food, clothing, shelter)

b. ☐ MEDICAL CARE (e.g. physical and mental health needs)

c. ☐ HEALTH and SAFETY HAZARDS (e.g. risk of suicide, unsafe environment)

d. ☐ MALNUTRITION/DEHYDRATION

e. ☐ FINANCIAL SELF-NEGLECT (e.g. inability to manage one's own personal finances)

f. ☐ OTHER ______________________________________

ABUSE RESULTED IN (✔ CHECK ALL THAT APPLY)

☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED

☐ DEATH ☐ MENTAL SUFFERING ☐ SERIOUS BODILY INJURY* ☐ OTHER (SPECIFY)________________________________

☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? DOES THE ALLEGATION INVOLVE A SERIOUS BODILY INJURY (see definition in section "Reporting Responsibilities and Time Frames" within the General Instructions)? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).*

☐ ✔ CHECK IF MEDICAL, FINANCIAL (ACCOUNT INFORMATION, ETC.), PHOTOGRAPHS, OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE *(family, significant others, neighbors, medical providers, agencies involved, etc.)*

NAME	RELATIONSHIP
ADDRESS	TELEPHONE ( )

H. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE *(If unknown, list contact person)*

NAME		IF CONTACT PERSON ONLY ✔ CHECK ☐	RELATIONSHIP
ADDRESS	CITY	ZIP CODE	TELEPHONE ( )

I. TELEPHONE REPORT MADE TO

☐ APS ☐ Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of State Hospitals
☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	TELEPHONE ( )	DATE/TIME

J. WRITTEN REPORT

Enter information about the agencies receiving this report. If the abuse occurred in a LTC facility and resulted in Serious Bodily Injury*, please refer to "Reporting Responsibilities and Time Frames" in the General Instructions. Do not submit report to California Department of Social Services Adult Programs Division.

AGENCY NAME	ADDRESS OR FAX	☐ Date Mailed	☐ Date Faxed
AGENCY NAME	ADDRESS OR FAX	☐ Date Mailed	☐ Date Faxed
AGENCY NAME	ADDRESS OR FAX	☐ Date Mailed	☐ Date Faxed

K. RECEIVING AGENCY USE ONLY

☐ Telephone Report ☐ Written Report

1. Report Received by Date/Time

2. Assigned ☐ Immediate Response ☐ Ten-Day Response ☐ No Initial Response (NIR)
☐ Not APS ☐ Not Ombudsman ☐ No Ten-Day (NTD)

Approved by Assigned to (optional)

3. Cross-Reported to ☐ CDPH-Licensing & Cert.; ☐ CDSS-CCL; ☐ Local Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse;
☐ Calif. Dept. of State Hospitals; ☐ Law Enforcement; ☐ Professional Licensing Board;
☐ Calif. Dept. of Developmental Services; ☐ APS;
☐ Other (Specify) Date of Cross-Report

4. APS/Ombudsman/Law Enforcement Case File Number

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE
GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. **Abuse** means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. **Neglect** means the negligent failure of an elder or dependent adult or of any person having the care or custody of an elder or a dependent adult to exercise that degree of self-care or care that a reasonable person in a like position would exercise. **Elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES AND TIME FRAMES:

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

***Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury, report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential Internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:

    - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
    - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.

- For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

REPORTING PARTY DEFINITIONS

Mandated Reporter (WIC Section 15630 (a)) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

Care Custodian (WIC Section 15610.17) means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing are or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code; (b) Clinics; (c) Home health agencies; (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services; (e) Adult day health care centers and adult day care; (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders; (g) Independent living centers; (h) Camps; (i) Alzheimer's Disease Day Care Resource Centers; (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code; (k) Respite care facilities; (l) Foster homes; (m) Vocational rehabilitation facilities and work activity centers; (n) Designated area agencies on aging; (o) Regional centers for persons with developmental disabilities; (p) State Department of Social Services and State Department of Health Services licensing divisions; (q) County welfare departments; (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys; (s) The Office of the State Long-Term Care Ombudsman; (t) Offices of public conservators, public guardians, and court investigators; (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities; or (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness; (v) Humane societies and animal control agencies; (w) Fire departments; (x) Offices of environmental health and building code enforcement; or (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

Health Practitioner (WIC Section 15610.37) means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.

Any officer and/or employee of a financial institution is a mandated reporter of suspected financial abuse and shall report suspected financial abuse of an elder or dependent adult on form SOC 342, “Report of Suspected Dependent Adult/Elder Financial Abuse”.

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under “Reporting Party Definitions”) any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine (WIC Section 15630(h)).

Officers or employees of financial institutions are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter, to the party bringing the action.

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

(1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
(2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
(3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
(4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency or agencies, the reporter shall send the written report to the designated agencies (as defined under “Reporting Responsibilities and Time Frames”); and keep one copy for the reporter’s file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS DIVISION.

Department of
SOCIAL SERVICES
CDSS

Adult Protective Services (APS) County Contact Information

This information is provided by the county, and placed here to help you find the appropriate county Adult Protective Services (APS) office. If you find that any of this information to be incorrect, please let us know at APBPolicy@dss.ca.gov and we will work to correct it. For full document, please visit http://www.cdss.ca.gov/agedblinddisabled/PG2300.htm. Thank you!

County / Website	County Address	Phone
Alameda County	Adult Protective Services 6955 Foothill Blvd., Third Floor Oakland, CA 94621	**24 Hour Abuse Hotline:** (866) 225-5277 (510) 577-3500 (510) 577-5615 fax
Alpine County	Department of Health & Human Services 75A Diamond Valley Road Markleeville, CA 96120	**24 Hour Abuse Hotline:** (530) 694-2235 **After hours, weekends, holidays:** (866) 900-0525 (530) 694-2252 fax
Amador County	Department of Social Services 10877 Conductor Blvd. Sutter Creek, CA 95685	**24 Hour Abuse Hotline:** (209) 223-6550 **After hours, weekend, holidays:** (209) 223-1075 (209) 257-0642 fax
Butte County	Department of Employment & Social Services P.O. Box 1649 Oroville, CA 95965	**24 Hour Abuse Hotline:** (800) 664-9774 (530) 538-7711 (530) 538-5093 fax
Calaveras County	Calaveras Works & Human Services 509 East Saint Charles Street San Andreas, CA 95249-9701	**24 Hour Abuse Hotline:** (209) 754-6452 **After hours, weekends, holidays:** (209) 754-6500 (209) 754-3293 fax
Colusa County	Department of Social Services 251 East Webster Street Colusa, CA 95932	**24 Hour Abuse Hotline:** (530) 458-0280 (530) 458-2664 fax

Contra Costa County	Adult Protective Services 400 Ellinwood Way Pleasant Hill, CA 94523	**24 Hour Abuse Hotline:** (877) 839-4347 (925) 602-4179 (925) 602-4195 fax
Del Norte County	Department of Health & Human Services 880 Northcrest Drive Crescent City, CA 95531-3485	**24 Hour Abuse Hotline:** (707) 464-3191 (707) 465-1783 fax
El Dorado County	Department of Social Services 3057-A Briw Road Placerville, CA 95667-1637	**24 Hour Abuse Hotline:** (530) 642-4800 (530) 622-1543 fax
Fresno County	Department of Social Services Adult Services, APS Senior Resource Center 2025 E. Dakota, 2nd Floor PO Box 1912 Fresno CA 93718-1912	**24 Hour Abuse Hotline:** (559) 600-3383 (800) 418-1426 (559) 453-8990 fax
Glenn County	Human Resources Agency P.O. Box 611 Willows, CA 95988-0611	**24 Hour Abuse Hotline:** (530) 934-1429 (530) 865-1243 fax
Humboldt County	Department of Health & Human Services 808 East Street Eureka, CA 95501	**24 Hour Abuse Hotline:** (707) 476-2100 (707) 455-7715 fax
Imperial County	Department of Social Services 2999 South 4th Street El Centro, CA 92243	**24 Hour Abuse Hotline:** (760) 337-7878 (760) 336-3945 (760) 336-8593 fax
Inyo County	Department of Health & Human Services 162 Grove Street, Ste. J Bishop, CA 93514	**24 Hour Abuse Hotline:** (760) 872-1727 or (800) 841-5011 (760) 872-1727 (760) 873-3277 fax
Kern County	Aging & Adult Services Department 5357 Truxton Avenue Bakersfield, CA 93309	**24 Hour Abuse Hotline:** (800) 277-7866 or (661) 868-1000 (661) 868-0923 fax

Kings County	Human Services Agency 1400 W. Lacey Blvd. Hanford, CA 93230	**24 Hour Abuse Hotline:** (866) 582-8776 (559) 582-3241 (559) 582-7399 fax
Lake County	Department of Social Services 15975 Anderson Ranch Parkway P.O. Box 9000 Lower Lake, CA 95457-9000	**24 Hour Abuse Hotline:** (888) 221-2204 (707) 995-4680 (707) 995-4662 fax
Lassen County APS is the last paragraph on this page. Title is not bolded.	Adult Services P.O. Box 1359 720 Richmond Rd. Susanville, CA 96130	**24 Hour Abuse Hotline:** (530) 251-8158 **After hours, weekends, holidays:** (530) 257-6121 (530) 251-8370 fax
Los Angeles County	Community & Senior Services 3333 Wilshire Blvd. Suite 400 Los Angeles, CA 90010	**24-Hour Elder Abuse Reporting Hotline:** (877) 477-3646 **APS Mandated Reporter Hotline:** (M-F, 8:30-5:00) (888) 202-4248
Madera County	Department of Social Services P.O. Box 569 Madera, CA 93639-0569	**24-Hour Abuse Hotline:** (559) 675-7839 (559) 622-8300 (559) 675-7983 fax
Marin County	Aging & Adult Services 10 North San Pedro Road San Rafael, CA 94903	**24 Hour Abuse Hotline:** (415) 473-2774 (415) 473-7118 (415) 473-6465 fax
Mariposa County	Social Services Division 5362 Lemee Lane P.O. Box 99 Mariposa, CA 95338	**24 Hour Abuse Hotline:** (209) 966-7000 **After hours, weekends or holidays:** (209) 966-3614 (209) 966-2000 (209) 966-8251 fax

Mendocino County	Health & Human Services 747 South State Street P.O. Box 839 Ukiah, CA 95482	**24 Hour Abuse Hotline:** Ukiah - (707) 463-7900 or (877) 327-1799 Fort Brag - (707) 962-1102 or (877) 327-1677 Willets - (707) 456-3740 or (800) 575-4357 Ukiah - (707) 467-5866 fax Fort Bragg - (707) 962-1110 Fax Willets - (707) 456-3741 fax
Merced County	Human Services Agency P.O. Box 112 Merced, CA 95341	**24 Hour Abuse Hotline:** (209) 385-3105 (209) 385-3000 (209) 725-3836 fax
Modoc County	Department of Social Services 120 North Main Street Alturas, CA 96101	**24 Hour Abuse Hotline:** (530) 233-6602 (530) 233-6536 fax
Mono County	Department of Social Services P.O. Box 2969 Mammoth Lakes, CA 93546	**24 Hour Abuse Hotline:** (800) 340-5411 (760) 924-1770 (760) 924-5431 fax
Monterey County	Department of Social Services 1000 S. Main Street, Ste. 211A Salinas, CA 93901	(831) 755-8500 main (831) 883-7565 APS (831) 883-7563 fax
Napa County	Health & Human Services 650 Imperial Way, Ste. 101 Napa, CA 93901-2936	**24 Hour Abuse Hotline:** (888) 619-6913 (707) 253-3818 (707) 253-6117 fax
Nevada County	Adult Services 500 Crown Point Circle, Ste. 130 Grass Valley, CA 95945	**24 Hour Abuse Hotline:** (888) 339-7248 (530) 274-3264 fax
Orange County	Social Services Agency P.O. Box 5687 Orange, CA 92863	**24 Hour Abuse Hotline:** (800) 451-5155 (714) 704-6161 fax

Placer County	Adult Protective Services 101 Cirby Hills Drive Roseville, CA 95678	**24 Hour Abuse Hotline:** (888) 886-5401 (916) 787-8860 (530) 265-9376 fax
Plumas County	Department of Social Services 270 County Hospital Rd. Ste. 207 Quincy, CA 95971	**24 Hour Abuse Hotline:** (530) 283-6471 **After hours, weekends, holidays:** (530) 283-6300 (530) 283-6368 fax
Riverside County	Department of Public Social Services Adult Services Division 4060 County Circle Drive Riverside, CA 92501	**24 Hour Abuse Hotline:** (800) 491-7123 (951) 358-3969 fax
Sacramento County	Department of Health & Human Services P.O. Box 269131 Sacramento, CA 95826	**24 Hour Abuse Hotline:** (916) 874-9377 (916) 874-9662 fax
San Benito County	Health & Human Services 1111 San Felipe Rd, Suite 206 Hollister, CA 95023-3801	**24 Hour Abuse Hotline:** (831) 636-4190 (831) 634-0780 fax
San Bernardino County	Human Services System 686 East Mill Street San Bernardino, CA 92415	**24 Hour Abuse Hotline:** (877) 565-2020 (909) 338-6718 fax
San Diego County	Aging & Independence Services P.O. Box 23217 San Diego, CA 92193-3217	**24 Hour Abuse Hotline:** (800) 339-4661 (800) 510-2020 (858) 495-5247 fax
San Francisco City and County	San Francisco Dept. of Aging & Adult Services 1650 Mission Street, 4th Floor San Francisco, CA 94103	**24 Hour Abuse Hotline:** (800) 814-0009 (415) 355-6700 (415) 355-3549 fax

San Joaquin County	Human Services Agency Aging & Community Services P.O. Box 201056 Stockton, CA 95201	**24 Hour Abuse Hotline:** (888) 800-4800 (209) 468-3780 (209) 468-2207 fax
San Luis Obispo County	Dept. of Social Services P.O. Box 8119 San Luis Obispo, CA 93403	**24 Hour Abuse Hotline:** (805) 781-1790 **After hours, weekends, holidays:** (800) 838-1381 (805) 788-2834 fax
San Mateo County	Health System Aging & Adult Services 225 37th Avenue San Mateo, CA 94403	**24 Hour Abuse Hotline:** (800) 675-8437 (650) 573-2310 fax
Santa Barbara County	Department of Social Services 234 Camino Del Remedio Santa Barbara, CA 93110 Santa Maria Office: Department of Social Services 2125 S. Centerpointe Parkway Santa Maria, CA 93455 Lompoc Office: Department of Social Services 1100 West Laurel Avenue Lompoc, CA 93436-9908	**24 Hour Abuse Hotline:** (844) 751-6729 Santa Barbara - (805) 681-4550 Santa Maria - (805) 346-8303 Lompoc - (805) 737-6020 Santa Barbara - (805) 681-4666 fax Santa Maria - (805) 346-7247 Lompoc - (805) 737-7094
Santa Clara County	Social Services Agency 333 W. Julian San Jose, CA 95010	**24 Hour Abuse Hotline:** (800) 414-2002 or (408) 975-4900 (408) 975-4910 fax
Santa Cruz County	Human Services Department P.O. Box 1320 Santa Cruz, CA 95061	**24 Hour Abuse Hotline:** (866) 580-4357 (831) 454-4290 fax
Shasta County	Department of Social Services 2460 Breslauer Way P.O. Box 496005 Redding, CA 96049-6005	**24 Hour Abuse Hotline:** (530) 225-5798 (530) 245-7693 fax

Sierra County	Dept. of Health & Human Services 202 Front Street P.O. Box 1019 Loyalton, CA 96118	**24 Hour Abuse Hotline:** (530) 289-3720 (530) 993-6700 (530) 993-6767 fax
Siskiyou County	Adult Services Department 2060 Campus Drive Yreka, CA 96097	**24 Hour Abuse Hotline:** (530) 842-7009 (530) 841-2700 (530) 841-4238 fax
Solano County	Health and Social Services Older & Disabled Adult Services P.O. Box 5050, MS 5-110 Fairfield, CA 94533	**24 Hour Abuse Hotline:** (800) 850-0012 (707) 784-8259 (707) 435-2440 fax
Sonoma County	Human Services Department P.O. Box 4059 Santa Rosa, CA 95402-1539	**24 Hour Abuse Hotline:** (800) 667-0404 (707) 565-5940 (707) 565-5969 fax
Stanislaus County	Community Services Agency P.O. Box 42 Modesto, CA 95355-0042	**24 Hour Abuse Hotline:** (800) 336-4316 (209) 558-2637 (209) 558-2681 fax
Sutter County	Department of Human Services 1965 Live Oak Blvd. Suite C Yuba City, CA 95991	**24 Hour Abuse Hotline:** (530) 822-7227 (530) 822-7384 fax
Tehama County	Department of Social Services P.O. Box 1515 Red Bluff, CA 96080	**24 Hour Abuse Hotline:** (800) 323-7711 (530) 527-1911 (530) 527-4836 fax
Trinity County	Dept. of Health and Human Services P.O. Box 1470 Weaverville, CA 96093-1470	**24 Hour Abuse Hotline:** (530) 623-1314 or (800) 851-5658 (530) 623-6628 fax
Tulare County	Health & Human Services Agency Adult Protective Services 3500 West Mineral King Road, Suite C	**24 Hour Abuse Hotline:** (877) 657-3092 (559) 730-9931 fax

	Visalia, CA 93291	
Tuolumne County	Department of Social Services 20111 Cedar Road North Sonora, CA 95370	**24 Hour Abuse Hotline:** (866) 388-7502 or (209) 533-4357 (209) 768-7753 (209) 533-7355 fax
Ventura County	Adult Protective Services Office 1001 Partridge Drive, Suite 365 Ventura, CA 93003	**24 Hour Abuse Hotline:** (805) 654-3200 (805) 650-1521 fax
Yolo County	Department of Employment & Social Services 137 N. Cottonwood Street, Ste. 1500 Woodland, CA 95695	**24 Hour Abuse Hotline:** (888) 675-1115 or (530) 661-2955 (530) 661-2750 (530) 661-2761 fax
Yuba County	Health and Human Services Agency 5730 Packard Avenue, Suite 1000 Marysville, CA 95901-9987	**24 Hour Abuse Hotline:** (866) 999-9113 or (530) 749-6471 (530) 749-6311 (530) 749-6244 fax

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Hospitalizations

Alzheimer's
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Hospitalization & Discharge Planning

Patients with cognitive impairment or dementia are often high-risk members because as the disease progresses, they are unable to manage self-care, including following hospital-based care protocols and discharge instructions. Failure to account for cognitive impairment will compromise efforts to deliver quality care in the hospital and upon discharge.

Some examples of how cognitive impairment or dementia directly impact care include:

- Inability of patients to accurately provide medical history
- Confusion in the hospital-based setting leading to safety concerns (for patient and/or staff)
- Management of co-existing conditions during hospitalization and once discharged
- Taking medications correctly
- Making and following through with post-discharge doctors' appointments and lab tests

Why identify and engage family/informal caregivers?

Family/informal caregivers are crucial partners in delivering quality care for those with cognitive impairment and dementia. Not only can they provide enormous assistance in the hospital and at home, they help navigate the entire continuum of care from admissions to post-discharge.

Despite the pivotal role that caregivers play, healthcare providers and systems of care may fail to identify family/informal caregivers and instead rely on patients with cognitive impairment or dementia to take care of themselves. Recognizing this link, California legislation now mandates that hospitals provide each admitted inpatient with the opportunity to identify one unpaid family caregiver who may assist in post-hospital care and record the designated caregiver's information in the patient's medical record. If the patient or legal guardian declines to designate a caregiver, the hospital must document the declination in the patient's medical record. If a caregiver has been identified, he/she must be notified of the patient's discharge or transfer to another facility as soon as possible, but at a minimum, upon issuance of a discharge order by the attending physician.

Provider Responsibilities:

- Identify patients who may have cognitive impairment and dementia, taking into consideration that:
  - Many people with cognitive impairment will not provide accurate self-reports of cognitive issues.

  - Many people with dementia have never received a formal diagnosis from their healthcare provider
- Dementia and delirium may be confused, especially in a hospital setting; differential diagnosis is important
- If a person has cognitive impairment, identify and engage a family/informal caregiver
  - Document the primary family/informal caregiver in the medical record, including relationship to patient and contact information
  - Share this crucial information with the Cal MediConnect health plan and provider group
  - Encourage the family/informal caregiver to actively participate in post-discharge care planning and the Interdisciplinary Care Team

Discharge Planning

When a person with cognitive impairment is discharged from the hospital, ensure that the family receives dementia-specific care transitions support and information.

- Link families to community-based organizations that specialize in Alzheimer's disease and related dementias
- Ascertain what the caregiver will be facing when returning home with the person with dementia, such as "what other family or social support will they have or need at home?"
- Provide families with dementia-specific information and necessary instructions, including care transitions resources that focus on people with cognitive impairment

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

Caring for the Caregiver

Alzheimer's
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Caregiver Health

Taking care of yourself is one of the most important things you can do as a caregiver. This could mean asking family members or friends to help out, doing things you enjoy, using adult day care services, or getting help from a local home health care agency. Taking these actions can bring you some relief. It also may help keep you from getting ill or depressed.

Here are some ways you can take care of yourself:

- Ask for help when you need it.
- Join a caregivers' support group.
- Take breaks each day.
- Spend time with friends.
- Keep up with your hobbies and interests.
- Eat healthy foods.
- Get exercise as often as you can.
- See your doctor on a regular basis.
- Keep your health, legal, and financial information up-to-date.

It's Okay to Ask for Help

Many caregivers find it hard to ask for help. They feel like they should do everything themselves, or that no one will help them even if they ask. They may think it's not right to leave the person with Alzheimer's disease with someone else. Maybe they cannot afford to pay someone to watch the person for an hour or two.

It's okay to ask for help from family and friends. You don't have to do everything yourself. If you have trouble asking for help, try these tips:

- Ask people to help out in specific ways like making a meal, visiting the person with Alzheimer's, or taking the person out for a short time.
- Join a support group to share advice and understanding with other caregivers.

Your Emotional Health

You may be busy caring for the person with Alzheimer's disease and don't take time to think about your emotional health. But, you need to. Caring for a person with Alzheimer's takes a lot of time and effort. Sometimes, you may feel discouraged, sad, lonely, frustrated, confused, or angry. *These feelings are normal.*

Here are some things you can say to yourself that might help you feel better:

- I'm doing the best I can.
- What I'm doing would be hard for anyone.
- I'm not perfect, but that's okay.
- I can't control some things that happen.
- Sometimes, I just need to do what works for right now.
- Even when I do everything I can think of, the person with Alzheimer's disease will still have problem behaviors because of the illness, not because of what I do.
- I will enjoy the moments when we can be together in peace.
- I will try to get help from a counselor if caregiving becomes too much for me.

Meeting Your Spiritual Needs

As the caregiver of a person with Alzheimer's, you may need more spiritual resources than others do. Meeting your spiritual needs can help you cope better as a caregiver and find a sense of balance and peace. Some people like to be involved with others as part of a faith community, such as a church, temple, or mosque. For others, simply having a sense that larger forces are at work in the world helps meet their spiritual needs.

Information adapted from the National Institute on Aging, part of the National Institutes of Health *www.nia.nih.gov*, NIH July 2012
Reviewed by ALZGLA November 2016

Caregiver Depression

Caring for someone with Alzheimer's disease can be a 24/7 task, and can be very challenging for a caregiver. There are many losses and changes experienced by the caregiver, and it is not uncommon for the caregiver to feel stress, anger, sadness, depression, isolation, and guilt. Often times, caregivers place all of their focus and energy on the person with Alzheimer's disease, and end up neglecting their own needs and health. It is important that caregivers of people with Alzheimer's focus on their own needs and get the support that they require.

Identifying Depression

- Are you feeling isolated? As though you are alone?
- Are you having uncomfortable feelings about your relationship with the person you are caring for?
- Are you having feelings of worthlessness or guilt?
- Are you feeling hopeless?
- Do you have thoughts of death or suicide?
- Are you feeling extra fatigued? Is it more difficult than usual to get out of bed?
- Are you neglecting your own health? Not eating? Over-eating? Missing medical appointments?
- Are you having trouble with your own thinking or memory?
- Are you experiencing headaches, stomach issues, or pain?
- Do you find yourself crying more than usual?

Tips

- Speak with a healthcare professional
- Join a support or education group, or identify a trusted friend, family, or community member to talk to when you are feeling this way. You do not have to go through this alone.
- Try to stay connected with family and friends.
- Focus on what you are able to do as a caregiver; remember that caregiving can be very challenging.
- Set realistic goals.
- Ask for help with caregiving from others.
- Try to take a break and do something you enjoy. Consider physical activities when possible, such as taking a walk.

Information adapted from the National Institute on Aging, part of the National Institutes of Health www.nia.nih.gov, NIH July 2012
Reviewed by ALZGLA November 2016

Understanding Respite

Most people with memory disorders are cared for at home. Since the course of these illnesses can last anywhere from three to twenty years, it is critical that the primary caregiver receive regularly-scheduled breaks from their ongoing role. Respite can occur in the home, or outside of the home, in many different ways. Here are some common types of programs that can help caregivers receive respite.

Adult Day Service programs

A safe, positive, caring, and relatively low-cost alternative to long-term placement of persons with dementia. These programs are designed to help people stay mentally and physically active, reduce isolation, improve their health, and prevent decline of their abilities. Research has shown that the use of Adult Day Service programs benefits both the caregiver and the person with dementia.

Services vary from center to center, but generally include therapeutic and recreational activities, transportation to and from the center, supervised social and educational activities, exercise, meals, walks, special events, nutrition, music, arts and crafts, guest speakers and family counseling.

In-Home Help

Caregiver’s can also receive respite by having someone come into the home to assist in caregiving for their loved one, so that he or she may take a break, or tend to his or her own health and needs. There are two levels of care available, based on the needs of the care recipient:

- Home Care, also known as companion care, is the social model. This level of care is appropriate for persons who need support and assistance with their activities of daily living (ADL’s) as well as supervision and socialization. This level of care is also known as “custodial care” and is provided by non-medical workers.
- Home Health Care is the medical model. This is a higher level of care appropriate for persons with dementia who are either in the later stages and/or have a secondary medical condition which requires some type of medical care, i.e. nursing.

There are two options available for securing in-home workers:

- Option 1: You may contract with a home care or home health care agency. In this option, the worker is employed and paid by the agency, and the agency interviews, screens, hires, trains and supervises the employees. Licensed agencies carry liability insurance and their workers are insured and/or bonded to protect you from theft and/or damages. Costs for this option are generally higher than option 2.
- Option 2: You may hire a private caregiver. In this option, you are the employer and assume all the responsibility for hiring, overseeing and monitoring the care as well as undertaking the liability and risk. This option is generally less expensive than option 1.

Informal Respite

Respite does not need to be provided by a professional. Caregivers can also find a trusted family member, friend, or community member who is willing and able to spend some time with the person with memory loss while the caregiver tends to personal needs, and/or takes some time for his or herself.

To learn more about respite programs, contact your local Alzheimer's organization.

Information adapted from the National Institute on Aging, part of the National Institutes of Health www.nia.nih.gov, NIH July 2012
Reviewed by ALZGLA November 2016

Alzheimer’s Greater Los Angeles Resources

Alzheimer’s
GREATER LOS ANGELES

ALZHEIMER'S GREATER LOS ANGELES PROGRAMS AND SERVICES

WHAT WE DO…

Alzheimer's Greater Los Angeles provides local, community based programs and services in many languages to help people with dementia, as well as their families, and caregivers, including:

24/7 HELPLINE

Alzheimer's Greater Los Angeles 24/7 Helpline 844.HELP.ALZ (844.435.7259) offers information, emotional support, and referrals for people with memory loss, caregivers, professionals, and general community members. The Helpline is staffed around-the-clock by professionals who understand the disease and its impact, and offers assistance in 170 languages.

CARE COUNSELING

Confidential Care Counseling and support helps families and caregivers of Alzheimer's disease with care planning, education and coping techniques. Individual and ongoing sessions, in person or by telephone, are available. Services are available in English and Spanish.

SUPPORT GROUPS

Alzheimer's Greater Los Angeles support groups are open gatherings of people with common needs and interests who come together to share their experiences in an effort to better cope with and manage the challenges of dementia in a safe environment, and are held at various times and locations, and in multiple languages.

EARLY STAGE PROGRAMS

Information, education, family consultation, and support groups are available for those with memory concerns or who have been diagnosed in the early stages of the disease and their care partners. Alzheimer's Greater Los Angeles offers educational programs and support groups for people in the early stage of the disease, as well as their care partners.

ACTIVITY PROGRAMS

Several activity programs are offered for persons living in the mid-stages of dementia, and their caregivers. Participants enjoy cognitively stimulating activities, mingling, light refreshments, and interactive presentations on music, art, yoga, and much more.

MEMORIES IN THE MAKING

This unique fine arts program that offers a creative and non-verbal way of communicating and capturing precious moments through art. Small group classes are held throughout the community at various sites and in different settings.

MedicAlert® FOUND CALIFORNIA

MedicAlert® Found California is a 24-hour, nationwide emergency response service for individuals with Alzheimer's disease or other dementias who wander and get lost, or have a medical emergency. An identification product provides emergency medical information and assists in the event of a wandering incident.

EDUCATION

Community outreach and education is offered throughout the Southland region on a variety of topics and are available in multiple languages. Educational classes for caregivers include Savvy *Caregiver*, a free six-week course that provides family caregivers with basic knowledge, skills, and attitudes to provide care to a family member who has memory loss, and *Savvy Express*, a three-session version of *Savvy Caregiver*.

PROFESSIONAL TRAINING

Alzheimer's Greater Los Angeles provides on-site and web-based trainings to professionals. Trainings can be customized to meet the specific needs of the training participants. Continuing education contact hours may be available.