

# California Alzheimer's Clinical Care Guideline: A Family Centered Approach to Care

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# Disclosure

- I will mention off-label use of medications in this presentation.

# Outline

- Rationale for updated guidelines
- Take away goals
- Review of the Guideline
  - New Policies and Practice Trends
  - Guideline Walkthrough
  - Implementation Tips
  - Case Examples

# Goals

- To adopt the California Alzheimer's Clinical Care Guideline
- Identify and assess the caregiver
- Recognize troublesome behavioral symptoms and know how to manage them
- Learn your community resources and make community connections

# Rationale for the Update

- 4<sup>th</sup> edition
- Addresses:
  - New scientific evidence
  - Improved clinical practice
  - Changes in state and federal law

# New Emphasis

- Focus on patient and family
- Role of care plan
- Role of community organizations for support
- Recognition of diversity amongst dementia patients and their families
  - Culture and values
  - Primary language and literacy level
  - Decision-making process

# New Government Policies

- Medicare Reimbursement
- Adoption of Physician Order for Life Sustaining Treatment (POLST)
- Social Security: Compassionate Allowance Benefit for Early-Onset individuals (<65 yo)
- CDC Healthy Brain Initiative

# Emerging Practice Trends

- Early Detection and Diagnosis
- Recognition of Mild Cognitive Impairment
- New Evidence about Antipsychotic Medications and FDA Black Box Warning Labels
- Gaps in Disclosure and Documentation
- Lifestyle Modifications

# The 2017 Guideline

- Assessment
- Care Plan
- Education and Support
- Important Considerations

<b>ASSESSMENT</b>	<b>Understand (or Know) the Patient</b>	
<b>Address the Patient Directly</b> <ul style="list-style-type: none"><li>• Confirm, disclose and document the diagnosis in the patient record.</li><li>• Identify the patient's culture, values, primary language, literacy level, and decision-making process.</li><li>• Identify the primary caregiver and assess the adequacy of family and other support systems, paying attention to the caregiver's own mental and physical health.</li></ul>	<b>Monitor and Reassess Changes</b> <p>Upon sudden changes or significant decline, and at least annually, conduct and document the following:</p> <ul style="list-style-type: none"><li>• Ability to manage finances and medications, as well as daily functions, including feeding, bathing, dressing, mobility, toileting and continence;</li><li>• Cognitive status, using a valid and reliable instrument, e.g., <a href="#">MoCA</a> (Montreal Cognitive Assessment), AD8 (Ascertain Dementia 8) or other tool;</li></ul>	<ul style="list-style-type: none"><li>• Comorbid medical conditions, which may present with sudden worsening in cognition and function or changes in behavior, and could complicate management of dementia;</li><li>• Emotional, behavioral and/or mood symptoms;</li><li>• Medications, both prescription and non-prescription, for appropriate use and contraindications; and</li><li>• Adequacy of home environment, including safety, care needs, and <a href="#">abuse and/or neglect</a>.</li></ul>
<b>CARE PLAN</b>	<b>Beneficial Interventions</b>	<b>Document Goals of Care</b>
<b>Disease Management</b> <ul style="list-style-type: none"><li>• Discuss the progression and stages of the disease.</li><li>• Evaluate and manage comorbidities in context of dementia and prognosis.</li><li>• Consider use of cholinesterase inhibitors, N-Methyl-D-aspartate antagonist, and other medications, if clinically indicated, to slow cognitive decline.</li><li>• Promote and refer to social services and community support.</li></ul> <b>Treat Emotional, Behavioral and/or Mood Symptoms</b> <ul style="list-style-type: none"><li>• First consider non-pharmacologic approaches such as counseling, environmental modification, task simplification, activities, etc.</li></ul>	<ul style="list-style-type: none"><li>• Consult with or refer to mental health professionals as needed.</li><li>• IF non-pharmacological approaches prove unsuccessful, THEN use medications targeted to specific emotions, behaviors or moods, if clinically indicated. Note, many medications carry an FDA black box warning and side effects may be serious, significant or fatal.</li></ul> <b>Evaluate Safety Issues</b> <ul style="list-style-type: none"><li>• Discuss driving, wandering, firearms, fire hazards, etc. Recommend <a href="#">medical identification</a> for patients who wander.</li></ul>	<ul style="list-style-type: none"><li>• Explore preferred intensity of care to include palliative care and end-of-life options such as hospice.</li><li>• Provide information and education on advance health care directives, Do Not Resuscitate Orders, <a href="#">Physicians Orders for Life Sustaining Treatment</a>, Durable Power of Attorney and other documents.</li><li>• <b>Promote Healthy Living</b><ul style="list-style-type: none"><li>• Discuss evidence in support of modifiable risk factors, e.g., regular physical activity and diet/nutrition.</li></ul></li><li>• <b>Refer to Clinical Studies</b><ul style="list-style-type: none"><li>• If interested, advise patient and family of opportunities to participate in <a href="#">research</a>.</li></ul></li></ul>
<b>EDUCATION AND SUPPORT</b>	<b>Engage with the Community</b>	
<b>Connect with Social and Community Support</b> <ul style="list-style-type: none"><li>• Involve the patient directly in care planning, treatment decisions and referrals to community resources.</li><li>• As the disease progresses, suggest appropriate home and community-based programs and services.</li><li>• Link the patient and caregiver to support organizations for culturally appropriate educational materials and referrals to community and government resources.</li></ul>		For statewide patient and family resources, link to: <b>California Department of Public Health, Alzheimer's Disease Program</b> (916) 552-9900 <a href="http://www.cdph.ca.gov/programs/Alzheimers/Pages/default.aspx">www.cdph.ca.gov/programs/Alzheimers/Pages/default.aspx</a> Check for local services in your area.
<b>IMPORTANT CONSIDERATIONS</b>	<b>Time Sensitive Issues</b>	<b>Eligibility for Benefits</b>
<b>Advance Planning</b> <ul style="list-style-type: none"><li>• Discuss the importance of basic legal and financial planning as part of the care plan and refer for <a href="#">assistance</a>.</li></ul> <b>Capacity Evaluations</b> <ul style="list-style-type: none"><li>• Assess the patient's decision-making capacity and determine whether a legal surrogate has been or can be identified.</li><li>• Consider literacy, language and culture in</li></ul>	<b>Elder Abuse</b> <ul style="list-style-type: none"><li>• Monitor for evidence of and report all suspicions of abuse (physical, financial, sexual, neglect, isolation, abandonment and/or abduction) to Adult Protective Services, Long-Term Care Ombudsman or the local police department, as required by law.</li></ul> <b>Driving</b> <ul style="list-style-type: none"><li>• <a href="#">Report the diagnosis</a> of Alzheimer's disease in</li></ul>	<ul style="list-style-type: none"><li>• Patients diagnosed with early-onset Alzheimer's disease may be eligible for <a href="#">Social Security compassionate allowance</a>.</li><li>• Other benefits may include Department of Veterans Affairs or long-term care insurance coverage under existing policies.</li></ul>

Assessment:  
Understand (or Know) the Patient

# 1. Address the Patient Directly

- Confirm, disclose and document the diagnosis in the patient record
- Identify the patient's culture, values, primary language, literacy level, and decision-making process
- Identify the primary caregiver and assess the adequacy of family and other support systems

# 1. Address the Patient Directly

- Confirm, disclose and document the diagnosis in the patient record
- Identify the patient's culture, values, primary language, literacy level, and decision-making process
- *Identify the primary caregiver and assess the adequacy of family and other support systems*

## 2. Monitor and Reassess Changes

- Annually and for sudden changes/decline, assess and document:
  - IADLs: finances, medications, etc.
  - BADLs: feeding, bathing, mobility, etc.
  - Cognitive status
  - Comorbid medical conditions
  - Emotional, behavioral, mood symptoms
  - Medications and supplements
  - Home environment (safety, care needs, abuse or neglect)

# ADL assessment

## Basic ADLs

Katz Index of Independence in Activities of Daily Living		
Activities Points (1 or 0)	Independence (1 Point)	Dependence (0 Points)
	NO supervision, direction or personal assistance.	WITH supervision, direction, personal assistance or total care.
<b>BATHING</b> Points: _____	<b>(1 POINT)</b> Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	<b>(0 POINTS)</b> Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
<b>DRESSING</b> Points: _____	<b>(1 POINT)</b> Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	<b>(0 POINTS)</b> Needs help with dressing self or needs to be completely dressed.
<b>TOILETING</b> Points: _____	<b>(1 POINT)</b> Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	<b>(0 POINTS)</b> Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
<b>TRANSFERRING</b> Points: _____	<b>(1 POINT)</b> Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	<b>(0 POINTS)</b> Needs help in moving from bed to chair or requires a complete transfer.
<b>CONTINENCE</b> Points: _____	<b>(1 POINT)</b> Exercises complete self control over urination and defecation.	<b>(0 POINTS)</b> Is partially or totally incontinent of bowel or bladder
<b>FEEDING</b> Points: _____	<b>(1 POINT)</b> Gets food from plate into mouth without help. Preparation of food may be done by another person.	<b>(0 POINTS)</b> Needs partial or total help with feeding or requires parenteral feeding.
<b>TOTAL POINTS:</b> _____	<b>SCORING:</b> 6 = High ( <i>patient independent</i> ) 0 = Low ( <i>patient very dependent</i> )	

## Instrumental ADLs

LAWTON - BRODY INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.)		
<b>Scoring:</b> For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).		
<b>A. Ability to Use Telephone</b>		<b>E. Laundry</b>
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely
2. Dials a few well-known numbers	1	2. Launders small items-rinses stockings, etc.
3. Answers telephone but does not dial	1	3. All laundry must be done by others
4. Does not use telephone at all	0	
<b>B. Shopping</b>		<b>F. Mode of Transportation</b>
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another
		5. Does not travel at all
<b>C. Food Preparation</b>		<b>G. Responsibility for Own Medications</b>
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication
4. Needs to have meals prepared and served	0	
<b>D. Housekeeping</b>		<b>H. Ability to Handle Finances</b>
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money
4. Needs help with all home maintenance tasks	1	
5. Does not participate in any housekeeping tasks	0	
<b>Score</b>		<b>Score</b>
<b>Total score</b>		
A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.		

# Mood Assessment: PHQ-9

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

# Care Plan: Beneficial Interventions

# 1. Disease Management

- Discuss the progression and stages of the disease
- Evaluate and manage comorbidities in context of dementia and prognosis

# Communication is Key to Successful Care Plan

- Communication with caregiver and patient is important
  - 50% of patients are not told their diagnosis even if it's documented in the chart

# Active Management

- Improves quality of life for patients and their caregivers
- Active management is:
  - Disclosure of diagnosis
  - Coordination of care among physicians, other healthcare professionals and lay caregivers
  - Becoming educated about the disease
  - Planning for the future

# Communication is Key to Successful Care Plan

- Assess where the patient and caregiver are in terms of knowing diagnosis and stages of disease
  - Feel out where the patient and family are at in terms of dealing with diagnosis?
  - What discussion are they ready to have?
  - What information do you think they need at this time? In the future?
  - Map out an approach for topics of discussion

# 1. Disease Management

- Consider use of acetylcholinesterase inhibitors (ACHE-I's) and N-methyl-D-aspartate (NMDA) antagonist and other medications if clinically indicated to slow cognitive decline
  - ACHE-I's: donepezil, galantamine, rivastigmine
  - NMDA antagonist: memantine
  - Combination: donepezil/memantine (Namzaric)

# 1. Disease Management

- Promote and refer to social services and community support
  - You are not alone!
  - Taking care of dementia patients requires a team
  - There are services available in your community to help you help your patients and caregivers

# Emotional, Behavioral and Mood Symptoms

- We know now that this is part and parcel of many disease processes or is a harbinger to cognitive changes coming later
- Imperative to deal with these issues as much as medical issues

## 2. Treat Emotional, Behavioral, and Mood Symptoms

- First consider non-pharmacological management
  - Counseling
  - Environmental modification
  - Task simplification
  - Caregiver training – reset expectations, education on what to expect
- Consult with or refer to mental health professionals as needed

## 2. Treat Emotional, Behavioral, and Mood Symptoms

- If non-pharmacological approaches are unsuccessful...
- Then use medications targeted to specific emotions, behaviors or moods if clinically indicated
  - FDA black box warning and side effects may apply to some medications (includes significant or fatal effects)
    - Use when patient is harm to self or others or behaviors impede ability to provide proper care

# Pharmacological Therapy

- Targeted to symptom
  - SSRI, not benzodiazepine, for symptoms of anxiety
  - SSRI, SNRI or bupropion for depression
  - SSRI, Memantine, trazodone, (or neurontin) first line for agitation
  - ACHE-I first line for visual hallucinations/delusions (e.g. Lewy Body dementia)

# Role of Antipsychotics

- Used for behaviors that are:
  - impeding care for patient
  - putting patient or caregiver in harm's way
- Specific behaviors
  - Delusions
  - Visual Hallucinations
  - Agitation or Aggression

# Antipsychotics

- Black Box Warning
  - Need to assess pros and cons for use
  - Frequently revisit reason for use in each patient
  - Reconsider tapering off once behavior has subsided
- Other cautions
  - Somnolence
  - Parkinsonism
  - Falls

# 3. Evaluate Safety Issues

- Discuss:
  - Driving, wandering, firearms, fire hazards
  - Recommend medical identification for patients who wander
    - E.g. Safe Return Bracelet

## 4. Document Goals of Care

- Communicating the plan is important for the care team and for future care providers.
  - Document in the chart!
- Explore preferred intensity of care to include palliative care and end-of-life options such as hospice
- Provide information and education on advance health care directives, DNR orders, POLST, Durable Power of Attorney, and other documents

# 5. Promote Healthy Living

- Discuss evidence in support of modifiable risk factors
  - E.g. regular physical activity, diet/nutrition

## 6. Refer to Clinical Studies

- If interested, advise patient and family of opportunities to participate in research
- Many families and patients want to participate but don't know how or who to trust
  - California Alzheimer's Disease Centers/Alzheimer's Disease Research Centers
  - [Clinicaltrials.gov](http://Clinicaltrials.gov)
  - Local Alzheimer's organization

# Education and Support: Engage with the Community

What a medical provider should do is **prescribe** something that would give you the **opportunity to learn about Alzheimer's** and have **interactions with others**. That would probably be the biggest help.

- Focus Group Participant



# Engage With the Community

- You, the patient and the family are not alone!
- Communicate with the patient and family to learn what they need and understand how to refer them!

# 1. Connect with Social and Community Support

- Involve the patient directly in care planning, treatment decisions and referrals to community resources
- As the disease progresses, suggest appropriate home and community-based programs and services

# 1. Connect with Social and Community Support

- Link the patient and caregiver to support organizations for culturally appropriate educational materials and referrals to community and government resources.

# 1. Connect with Social and Community Support

- Statewide patient and family resources:  
California Department of Public Health, Alzheimer's Disease Program  
(916) 552-9900  
<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/AlzheimersDisease.aspx>

# Local Social Services and Community Support

- Academic/state-funded Alzheimer's Centers
  - CADCs located throughout the state
- Your local Alzheimer's organization
- Various community organizations
  - Jewish Family Services, Partners in Care
  - Bet Tzedek Legal Services
- Local community programs
  - Wise and Healthy Aging, One Generation, OPICA, Senior Care Network, Leeza's Place

This list is only a sample of the many resources that exist in the community!

# Caregiver Interventions

- Care Management
- Psycho-educational approaches
- Counseling
- Support Groups
- Respite
- Psychotherapeutic approaches
- Combinations of above

Pinquart et al 2003 and Gaugler et al 2014,  
cited in Facts and Figures 2018, Alzheimer's Association

# Caregiver Tip Sheets

- Multiple topics
- English, Spanish, and Chinese
- Free to download

[www.alzgia.org/professionals](http://www.alzgia.org/professionals)



## 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



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

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

## 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

# ALZ Direct Connect Referral Program



## ALZ DIRECT CONNECT REFERRAL PROGRAM

...partnering with Healthcare and Aging Service Providers to *improve care and support* for people with Alzheimer's or dementias & their families

**ALZ DIRECT CONNECT** allows healthcare and aging services providers to directly link patients/clients and families to **Alzheimer's Greater Los Angeles** for:

- access to **care coordination and psychosocial support**
- referrals to **supportive services** (often at no cost)
- help with **understanding the disease & navigating its progression**
- a 360 approach to care through **feedback to the referring provider**



**ADDITIONAL QUESTIONS?**  
Contact (323) 930-6277

ALZ DIRECT CONNECT does not fulfill mandatory legal reporting requirements for healthcare professionals. Alzheimer's Greater Los Angeles maintains high professional & critical standards for care & safety and therefore reports any and all allegations or suspicions of elder abuse and/or child abuse.



24/7 Helpline – 844.HELP.ALZ | 844.435.7259 | alzgla.org

### ALZ DIRECT CONNECT REFERRAL FORM

Fax or email this form to Alzheimer's Greater Los Angeles

Fax # 323.686.5106

Email [alzdirectconnect@alzla.org](mailto:alzdirectconnect@alzla.org)

Date \_\_\_\_\_

Check if primary contact

PATIENT/CLIENT NAME

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_

Email \_\_\_\_\_

Primary Language:  English  Spanish  Other (specify) \_\_\_\_\_

Is the patient/client on Medi-Cal AND Medicare?

Yes  No

Check if primary contact

FAMILY CAREGIVER NAME (if available)

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_

Email \_\_\_\_\_

Relationship to Patient/Client:  Spouse/Partner

Child  Professional Caregiver  Other (specify) \_\_\_\_\_

Primary Language:  English  Spanish  Other (specify) \_\_\_\_\_

I give permission to the referring provider to forward my contact and patient information to Alzheimer's Greater Los Angeles. I understand that a representative will contact me and/or my caregiver about support, programs, and other services and will follow up with the referring provider. Referrals will be entered into our secure database, unless indicated otherwise by checking this box .

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient/Client or Personal Representative/Family Caregiver)

The person being referred provided verbal consent instead of signature  Yes

#### REASON FOR REFERRAL (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Social Work Consultation & Support | <input type="checkbox"/> Research & Clinical Trials Information |
| <input type="checkbox"/> Support for Newly Diagnosed        | <input type="checkbox"/> Legal & Financial Considerations       |
| <input type="checkbox"/> Support Groups                     | <input type="checkbox"/> Healthcare Directives                  |
| <input type="checkbox"/> Activity Programs                  | <input type="checkbox"/> Respite Services                       |
| <input type="checkbox"/> Safety Issues                      | <input type="checkbox"/> Caregiver Education                    |
| <input type="checkbox"/> Home Safety                        | <input type="checkbox"/> Other (specify) _____                  |
| <input type="checkbox"/> Driving                            |   |
| <input type="checkbox"/> Wandering (Medicalert)             |   |

Additional information

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### REQUIRED INFORMATION

Referring Provider Name \_\_\_\_\_ Title \_\_\_\_\_

Provider Organization \_\_\_\_\_  Healthcare organization  
 Non-medical community organization

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

How would you prefer to receive follow-up?  Fax  Email  Follow-up unnecessary



# Important Considerations: Time Sensitive Issues

# 1. Advance Planning

- Discuss importance of basic legal and financial planning as part of care plan – refer for assistance
- <http://www.211california.org>

## 2. Capacity Evaluations

- Assess patient's decision-making capacity and determine whether a legal surrogate has been or can be identified
- Consider literacy, language and culture in assessing capacity

# 3. Elder Abuse

- Monitor for evidence of abuse
  - Physical
  - Financial
  - Sexual
  - Neglect, Isolation, Abandonment
  - Abduction
- Report all suspicions of abuse to Adult Protective Services, Long-Term Care Ombudsman or local police department, as required by law

## 4. Driving

- Report diagnosis of Alzheimer's disease (and dementia) in accordance with California Law
- Reports go to your county health department
  - type: “confidential morbidity report [insert your county]”
  - For LA County:  
<http://publichealth.lacounty.gov/acd/reports/CMR-H-794.pdf>

# LA County Confidential Morbidity Report



COUNTY OF LOS ANGELES • DEPARTMENT OF PUBLIC HEALTH

## MORBIDITY UNIT CONFIDENTIAL MORBIDITY REPORT



NOTE: This form is not intended for reporting STDs, HIV, AIDS or TB. See comments below

DISEASE BEING REPORTED:			DISTRICT CODE (internal use only):		
Patient's Last Name:		Social Security Number:		Ethnicity (check one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic / Non-Latino	
First Name and Middle Name (or initial):		Birthdate (MM/DD/YYYY):	Age:	Race (check one): <input type="checkbox"/> White <input type="checkbox"/> African American / Black <input type="checkbox"/> Native American / Alaskan Native <input type="checkbox"/> Other _____ <input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other _____	
Address (Street and number):					
City/Town		State <input type="button" value="v"/>	Zip code		
Home Telephone Number:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Estimated Delivery Date: _____			
Work Telephone Number:					
Patient's Occupation or Setting: <input type="checkbox"/> Day Care <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Food Service (Explain): _____ <input type="checkbox"/> Health Care <input type="checkbox"/> School <input type="checkbox"/> Other (Explain): _____					
Date of Onset (MM/DD/YYYY):		Health Care Provider:		Risk Factors / Suspected Exposure Type: (check all that apply) <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Needle or blood exposure <input type="checkbox"/> Child care	

# Eligibility For Benefits

- Patients diagnosed with early-onset Alzheimer's disease may be eligible for Social Security compassionate allowance
- Other benefits may include:
  - Veterans Affairs
  - Long-Term Care insurance coverage under existing policies

# Case Examples

# Case 1

- 72 year old caucasian woman
- Accompanied by daughter
- Hypertension, chronic afib-rate controlled, depression
- Diagnosed on east coast with dementia with Lewy bodies,
  - significant agitation and delusions in the past
- Meds: rivastigmine, multiple antidepressants, and quetiapine
- Just moved to LA, living with daughter
- Need to establish medical care, seeking support

# My Assessment

- Reviewed outside workup and do medical/cognitive evaluation- agree with diagnosis
- No red flags on exam
  - Parkinsonism minimal, visual hallucinations not causing a problem, sleeping ok
  - MOCA 17/30

# My Concerns

- Significant history of depression, on lamotrigine, mirtazapine, bupropion
  - need geriatric psychiatrist
- History of agitation requiring quetiapine
  - Need to reassess periodically
- Cannot live on own – definite IADL difficulties but patient does not have great insight on this
- Daughter overwhelmed – needs guidance for behavioral management, finding services, financial/future care planning

# My Plan

1. No changes to medications – patient is stable
2. Gave names of geriatricians in her area to establish primary care
3. Referral to geripsychiatrist
4. Safe Return Bracelet
5. Referrals to:
  - Alzheimer's Greater LA (Direct Connect)
    - Financial, future care/paperwork, support groups, behavioral management, day programs
  - An independent referral service that assists with finding assisted living facilities
  - UCLA Dementia Care Program
6. Exercise
7. Healthy diet
8. Encourage social and cognitively stimulating activities

# Visit #2

- Has established care with geriatrician
- Has established care with Dementia Care Program
  - Both teams encouraging psychiatric referral
  - Both teams following meds/assessing need for antipsychotic
- Care plan more established:
  - Has help in the home for 3 days a week
  - Goes to Wise and Healthy Aging 2 days a week
  - Still a 2 hour gap in late afternoon when patient is alone at home
- Having more falls
- Had recent admission to hospital for pneumonia – has been more confused since then
- Patient upset at thought of moving to assisted living facility

# Plan

- No change to meds
- Reassure daughter than confusion is normal with medical problems,
  - hopefully will improve but can take time
- Safe Return Bracelet
- Reviewed fall precautions
  - Home Safety evaluation if patient going to stay in home
  - Physical therapy for gait/balance training
- Encourage to keep having conversation about assisted living
- Follow up with geriatrician and Dementia Care Program
  - Will continue to work on paperwork/future care plan
  - Psychiatry referral
  - Safety
  - Caregiver support

Need Assistance?  
Contact your local CADDC!



## **Southern California**

- UCLA
- USC Rancho Los Amigos
- USC Los Angeles
- UC Irvine
- UC San Diego

## **Northern California**

- UC Davis-Sacramento
- UC Davis – East Bay
- UCSF-San Francisco
- UCSF – Fresno
- Stanford University

<https://www.cdph.ca.gov/Programs/CCDPPHP/DCCDIC/CDCB/Pages/CaliforniaAlzheimersDiseaseCenters.aspx>

# Thank you!

- Sarah Kremen, MD
  - Director, UCLA CADDC, Mary S. Easton Center for Alzheimer's Disease Research at UCLA
  - 310-794-3665 or 310-794-6039
  - <http://eastonad.ucla.edu>
    - Memory/cognitive assessment
    - Clinical Trials
    - Caregiver Support groups

# Case 1

- 77 year old African American man
- Accompanied by daughter
- Hypercholesterolemia, memory loss, delusions, insomnia
- Living with long time friend
- IADLs: daughter helping with bills, has concerns about his meals, is driving and not getting lost
- Cognitive testing demonstrates orientation, memory, and visual constructional deficits
- Tearful, Geriatric Depression Scale score 10/15

# My Concerns and Plan Formulation

- Dementia, probably Alzheimer's disease
  - Depression with insomnia
  - Delusions
  - Memory/cognitive issues
  - Driving
  - Living alone → diet/meals
  - Planning → pension, DPOA, Advanced Directive, and then POLST

# What did I do?

1. Disclosed diagnosis
2. Did discuss:
  - memory problems and depression
    - Discussed with patient and daughter what was the most bothersome symptom?
    - Memory or depression? → depression
    - Started antidepressant
  - how to deal with meals
  - exercise, social and cognitively stimulating activities

# What did I do?

3. Did not discuss delusions directly with patient because he had not told me these concerns
  - did discuss in a separate conversation with daughter
  - Felt that though concerning, could wait to treat for now

# What was in my plan for the next visit?

- Reassess depression
- Assess whether antidepressant helps reduce insomnia or delusions
- Start a memory medication
- Will address delusions – see if memory medication will help quell delusions
- Discuss driving and CMR
- Discuss living situation plans
- Discuss future care planning/paperwork

# Visit #2

- Assessed depression
  - Improved but still bothersome – increased antidepressant
- Assessed delusions
  - Discussed briefly with patient by asking if he was worried about anything
- Wait to treat at future visit:
  - Adding memory medication
  - Management of delusions (?need med)
- Discussed driving – completed CMR after visit
- Discussed living situation – daughter already had a plan, looking at assisted living facilities
- Exercise, social and cognitively stimulating activities

# Visit #3

- Assessed depression
  - Much better (mood and sleep, delusions mildly improved)
- Added memory medication
  - Acetylcholinesterase inhibitor –for memory and to see if it will help with delusional thinking
- Follow up on driving – has heard from DMV, has appointment
- Encouraged exercise, social and cognitive stimulation

# Visit #4

- Depression assessment – better
  - Sleep also better
- Memory assessment – a little better, tolerating med, can increase
- Delusion assessment – less intrusive, no need for antipsychotic
- Driving – not driving
- Living situation - just moved to assisted living facility – assessed his adjustment there
  - Diet/meal concern no longer a concern
  - Making friends, participating in activities
  - Can get help with laundry, other IADLs
- Paperwork is completed – pension; working on POLST