Dementia Friendly Health Care

Health care professionals play a key care and support role for people with dementia and their care partners. They can promote timely detection and diagnosis, provide ongoing medical care, educate about dementia, and connect people with community resources that promote quality of life. Health care settings with a dementia champion and system-wide practices for dementia can advance a community's effort to be supportive of everyone touched by the disease.

Practicing Early Detection and Diagnosis

Receiving an Alzheimer's diagnosis can bring understanding and relief to both the patient and their care partners. Benefits can include:

- Maximizes a person's time to make decisions and plan for the future.
- Allows early access to services and support.
- Reduces health-related and other risks, including future financial implications.
- Improves clinical outcomes and medical management.

Implementing Dementia Care Best Practices

- Obtain training on dementia care best practices across the care continuum and provide throughout the health care setting.
- Assess a patient's cognitive health using objective tools such as the Mini-Cog or Montreal Cognitive Assessment (MoCA), provide a complete dementia workup, and disclose and document a diagnosis.
- Explain the diagnosis and disease process to the patient, including possible treatments, what to expect with memory loss and behavior changes, and ideas for staying active and engaged.
- Refer the person to specialists and resources for counseling, education, and planning.

Implementing Dementia Care Best Practices (cont.)

- Develop a person-centered care plan that maximizes abilities, function, and quality of life; manages medications and chronic diseases; provides referrals to services and support for the patient and care partner; addresses home and personal safety and independence (e.g., fall risk, mobility/ sensory needs, driving); facilitates advance care, financial, and legal planning; and promotes positive behavioral health.

Using a Coordinated, Person-Centered Approach

To maximize the person's abilities, function and quality of life:

- Treat conditions that may worsen dementia symptoms or lead to poor outcomes, including depression and co-existing medical conditions.
- Encourage the patient to stop smoking and limit alcohol consumption; encourage lifestyle changes that may reduce disease symptoms or slow their progression; and encourage routines for regular physical activity and healthy eating.
- Recommend occupational and/or physical therapists who have strategies for staying independent as the disease progresses.
- Address sensory issues or impairments.
- Encourage socialization and engagement in activities the patient enjoys.

To best manage medications:

- Review and simplify prescribed and over-the-counter medications, including vitamins and herbal remedies; refer to pharmacist as needed.
- Create a plan that educates the patient and care partner on medication management aids (pill organizers, dispensers, alarms) and recommend that the care partner or health care professional oversee/dispense medications, as needed.
- Avoid or minimize anticholinergics, hypnotics (benzodiazepines, zolpidem), H2-receptor antagonists, and antipsychotics.
- Evaluate the medications for over- and underuse and appropriate/safe use.
- Reassess the value of all medication, including any used for cognitive symptoms; consider a slow taper if continued benefit is uncertain.

Note: There is no FDA-approved medication for behavioral and psychological symptoms of dementia nor strong scientific evidence to support any particular class of medications. Document informed consent in the medical record and counsel care partners to watch for decreased functional or cognitive status, sedation, falls or delirium.

To initiate non-pharmacologic approaches that may reduce symptoms:

- Plan activities that involve current capabilities, interests, and repetitive motion.
- Give the patient tasks that match his/her level of competency.
- Train care partners to communicate, validate, redirect, and re-approach.
- Reinforce that routine is essential. Control the level of stimulation in the person's environment.

Using a Coordinated, Person-Centered Approach (cont.)

- Consider pharmacologic intervention only when non-pharmacologic interventions consistently fail or the person is in danger of doing harm to self or others or experiencing intolerable psychiatric suffering. Attempt to wean or discontinue medication as soon as possible.

To provide patient and care partner services and support:

- Refer to Alzheimer's Association Minnesota North Dakota and Senior LinkAge Line®.
- Encourage patients and care partners to connect with others and engage in health and wellness activities.
- Remind care partners to take care of their own health and well-being, including regular medical checkups.
- Encourage care partners to talk with others about the diagnosis so people can understand and provide support; encourage them to ask for help from family and friends; recognize and respond to signs of burnout.

To promote home and personal safety and independence:

- Refer the patient to an occupational and/or physical therapist to address fall risk, recommendations for sensory/mobility aids, home safety and accessibility modifications, and/or driving evaluation.
- Refer the patient to a driving rehabilitation specialist for clinical and/or in-vehicle evaluation.
- Report an at-risk driver.
- Refer the patient to MedicAlert®+ Alzheimer's Association Safe Return® when appropriate.
- Report suspected abuse, neglect, or financial exploitation.

To facilitate advance care, financial and legal planning:

- Discuss care goals, values and preferences with the patient and family.
- Encourage the patient and family to discuss and document preferences for care early on to prepare for later stages when decision-making is more difficult.
- Recommend that the patient assign a durable power of attorney and complete a healthcare directive and other legal and financial planning and documents. .
- Complete POLST (Provider Orders for Life Sustaining Treatment) when appropriate, and routinely re-evaluate and modify plan of care as appropriate.
- Discuss the role of palliative care and hospice in addressing pain and suffering.

To promote positive behavioral health:

- Rule out delirium for any acute changes in behavior.
- Describe and categorize the behavior, keeping in mind that behavior is a way to communicate.
- Identify and address unmet needs or reversible conditions.
- Support the care partner through self care suggestions, respite, and education on tactics such as minimizing confrontation and arguing and simplifying the home environment.

Resources in Your Community

Alzheimer's Association Minnesota North Dakota
The 24/7 Helpline serves people with memory loss, care partners, health care professionals, the general public, diverse populations, and concerned friends and family. The Helpline offers referrals to local community programs and services, dementia-related education, crisis assistance and emotional support. Call 1-800-272-3900 or visit www.alz.org/mnnd

Senior LinkAge Line®
This resource provides information, assistance and connections to various services and resources in your community. Call 1-800-333-2433 or visit www.MinnesotaHelp.info®

Take Action

Using the ACT on Alzheimer's provider practice tools, video tutorials, dementia education and dementia in person training will help your health care setting become dementia competent and a leader in providing quality dementia care for all.

www.actonalz.org/provider-resources

Minnesotans working together to transform Alzheimer's through social change and community engagement.