Alzheimer's and Dementia

Participant Manual

THE SUPREME COURT *of* OHIO
JUDICIAL COLLEGE

THE SUPREME COURT *of* OHIO

ALZHEIMER'S AND DEMENTIA

PARTICIPANT MANUAL

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ALZHEIMER'S AND DEMENTIA

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Course Developed December 3, 2018

FACULTY BIOGRAPHIES

TRICIA BINGHAM, MA, LSW, has been the Director of Programs and Services for the Alzheimer's Association Central Ohio Chapter since 2014. She provides leadership and direction for the development, implementation and evaluation of all programs and services in the Central Ohio Chapter territory which includes 14 Ohio counties. Ms. Bingham holds a Master of Arts in Gerontology from the University of Central Oklahoma in 2013. She obtained her Bachelor of Science in Sociology and a Minor in Gerontology from Illinois State University in 1988. She is a Licensed Social Worker in the State of Ohio. Ms. Bingham has more than 30 combined years in the aging field as a professional and volunteer providing education to caregivers, persons living with dementia, paraprofessionals and community members.

DR. DOUGLAS SCHARRE, the Medical Director of The Ohio State University Center for Cognitive and Memory Disorders, Interim Chair of the Department of Neurology, a clinical neuroscience researcher, Professor of Clinical Neurology, and a master clinician regarding diagnosis and management of cognitive issues. He has conducted over 150 cognitive and dementia related multi-center and investigator initiated clinical trials in the last 25 years. He designed and developed both paper and digital versions of the Self-Administered Gerocognitive Examination (SAGE), a cognitive assessment instrument designed for identifying individuals in a practical way with mild cognitive impairment or early dementia from any cause and to be sensitive to changes over time. He is a member of the Alzheimer’s Disease Cooperative Study (ADCS) group and is on the steering committee and has participated in all of the Alzheimer’s Disease Neuroimaging Initiative (ADNI) projects. He has conducted or participated in many studies utilizing neuroimaging (anatomical and functional (resting and task-activated) MRI, PET, and SPECT), serum and cerebrospinal fluid biomarkers, cognitive biomarkers, genetic biomarkers, and cognitive, functional, and behavioral scales on dementia and control subjects. He currently maintain repositories for brain tissue, cerebrospinal fluid and serum (brain and biomarker banks) on cognitively impaired and dementia subjects that researchers can utilize.

PAULA M. TALIAFERRO, MGS, LSW is an Educational Consultant in the field of aging and has developed and presented over 700 workshops since 1986 to professionals in the field of aging, paraprofessionals, older adults, and families. She holds a Master’s Degree in Gerontology from Miami University and is a Licensed Social Worker in the State of Ohio. She has worked in the field of aging since 1977 in both institutional and community based settings. Paula has written numerous workshops which are used widely in Ohio to train staff, volunteers, and clients. She is a PAC approved trainer under Teepa Snow's Positive Approach Certification. Paula has also been a key planner and faculty member for the Judicial College’s Adult Guardianship Education Program.

SUPREME COURT OF OHIO JUDICIAL COLLEGE

Adult Guardianship Continuing Education: Alzheimer's and Dementia

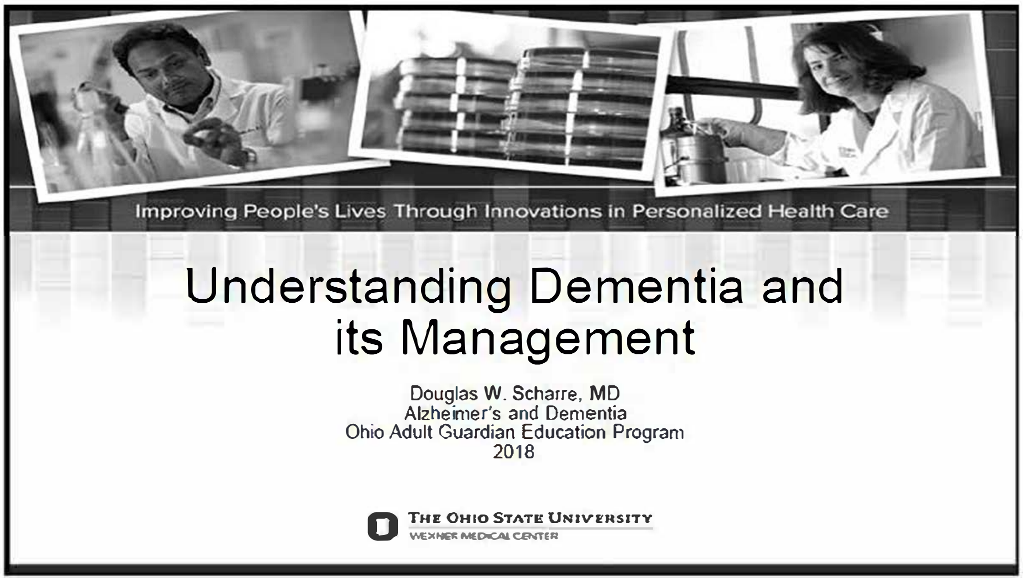
Session Agenda

Welcome & Introductions	Judicial College Staff
Understanding Dementia and its Management	***Douglas Scharre, MD*** The Ohio State University Wexner Medical Center
Responding to Common Challenges in Caring for Someone with Dementia in Ways that Create a Supportive Environment	***Paula M. Taliaferro, MGS, LSW*** Central Ohio Area Agency on Aging
Ohio Alzheimer's Association Programs and Resources	***Tricia Bingham, MA, LSW*** The Alzheimer's Association, Central Ohio Chapter
Adjourn	

Understanding Dementia and its Management

1. **PowerPoint**

Douglas Scharre, M.D.
The Ohio State University Wexner
Medical Center

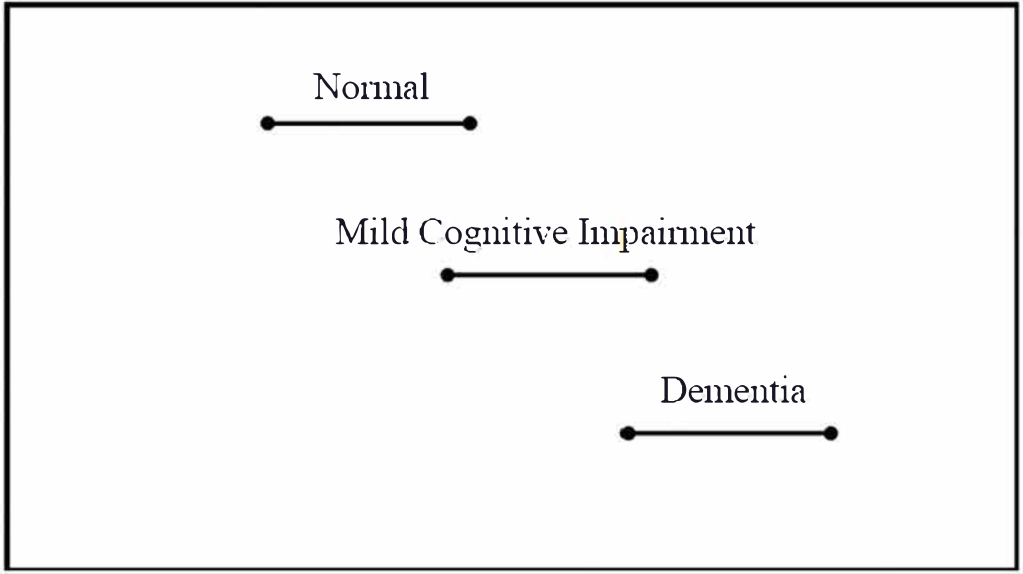


Improving People's Lives Through Innovations in Personalized Health Care

Understanding Dementia and its Management

Douglas W. Scharre, MD
Alzheimer's and Dementia
Ohio Adult Guardian Education Program
2018

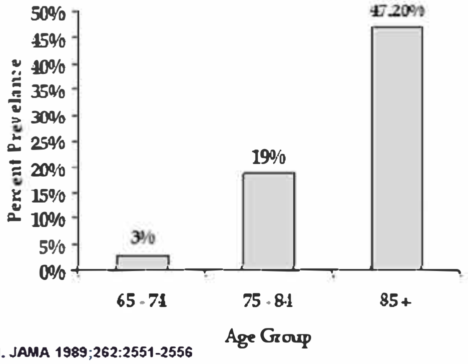
The Ohio State University
Wexner Medical Center



Dementia Definition

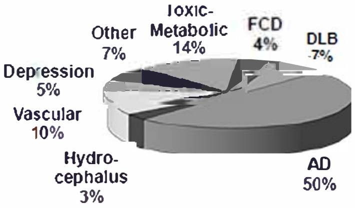
- Syndrome of acquired persistent intellectual impairment
- Persistent deficits in at least three of the following:
  - memory
  - language
  - visuospatial
  - personality or emotional state
  - cognition
- Resulting in impairment in Activities of Daily Living (ADL)
- Mild Cognitive Impairment (MCI): As above except mostly intact ADLs

Prevalence of Dementia Increases with Age



Evans, et al. JAMA 1989;262:2551-2556

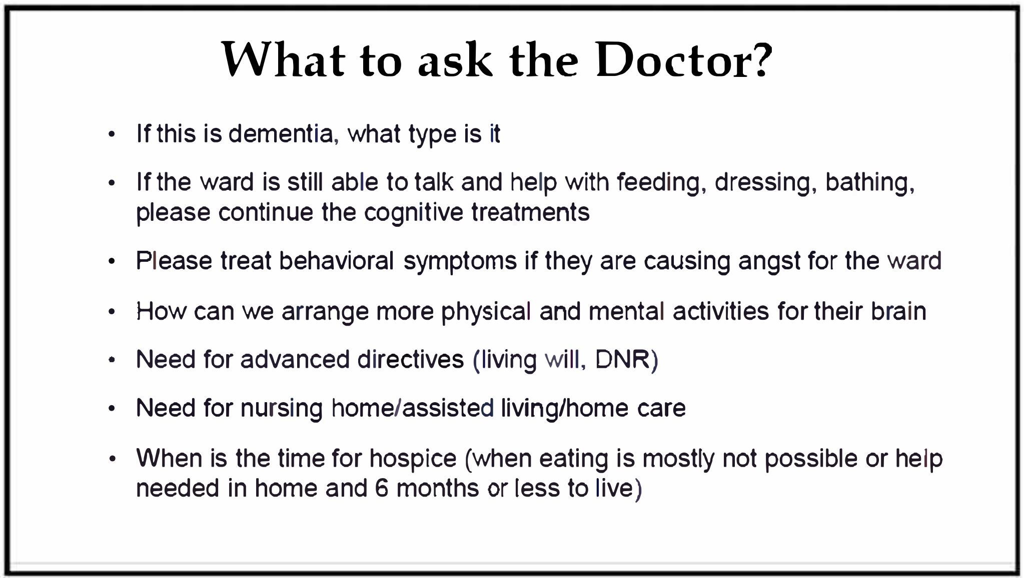
Prevalence of Dementia Syndromes



AD = Alzheimer's disease; DLB = Dementia with Lewy bodies; FCD = Focal cortical degeneration

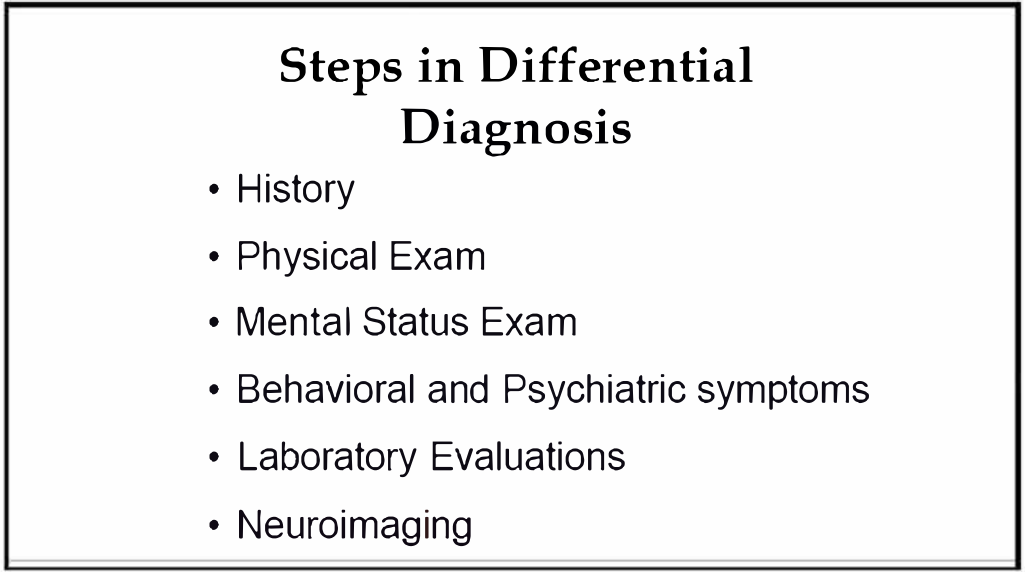
When to see the Doctor?

- Go to Primary Care Physician (PCP) as soon as cognitive changes noticed
- Cognitive screening: start at age 65 (Medicare Annual Wellness Visit)
- Seek specialist if PCP ignores complaints, rapid changes, young age of onset, or behavioral issues
- Start treatments as soon as symptoms begin, delay = faster brain damage; cognitive and functional loss



What to ask the Doctor?

- If this is dementia, what type is it
- If the ward is still able to talk and help with feeding, dressing, bathing, please continue the cognitive treatments
- Please treat behavioral symptoms if they are causing angst for the ward
- How can we arrange more physical and mental activities for their brain
- Need for advanced directives (living will, DNR)
- Need for nursing home/assisted living/home care
- When is the time for hospice (when eating is mostly not possible or help needed in home and 6 months or less to live)



Steps in Differential Diagnosis

- History
- Physical Exam
- Mental Status Exam
- Behavioral and Psychiatric symptoms
- Laboratory Evaluations
- Neuroimaging

History

- Onset
- Clinical course
- Past medical history
- Psychiatric illness
- Medications
- Social and family history

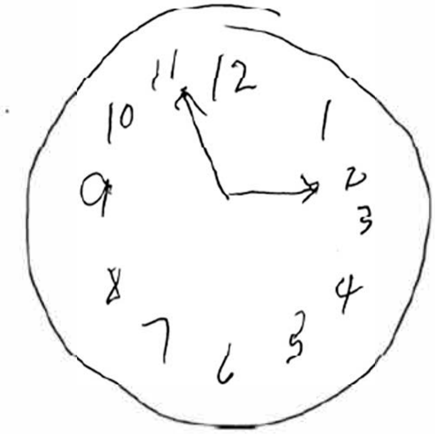
Physical Examination

- Systemic illness
- Endocrine dysfunction
- Neurologic focal findings
- Movement disorders
- Gait apraxia and incontinence (classic for normal pressure hydrocephalus)

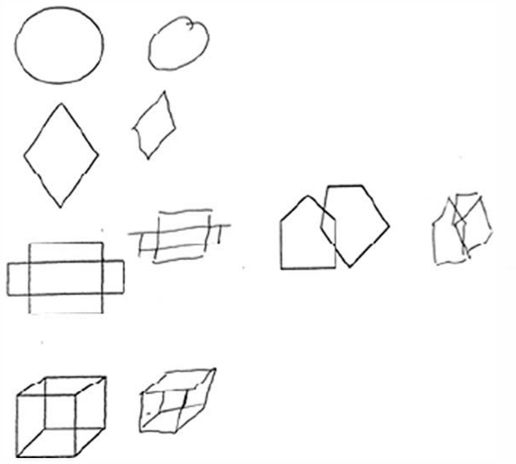
Mental Status Exam

- Attention
- Language
- Memory
- Visuospatial skills
- Abstraction and calculations
- Judgment and executive fxn
- Personality and emotional state

Clock Draw Test



Construction Tests



Importance of Early Diagnosis of MCI and Dementia

- Plaques possibly start 20 years before clinical symptoms of AD
- 16 million projected to have AD by 2050
- Current AD meds work better if started earlier
- Disease modifying agents are coming
- Preventing or delaying AD could save billions of dollars and lead to improved quality of life for patients and families

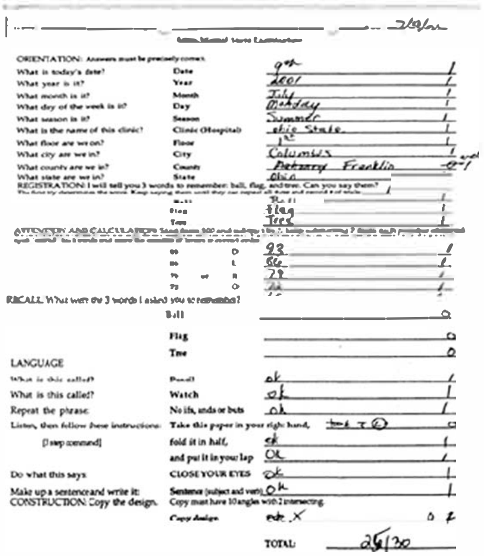
Barriers to Early Diagnosis of MCI and Dementia

- Patients with MCI and early dementia have impaired insight
- First present to the doctor an average of 3.5 years after cognitive symptoms start
- Physicians may not notice subtle cognitive deficits in routine office visits
- Little reimbursement for cognitive screens
- Often too much time or personnel resources required to administer testing

Barker WW et al. Alzheimer Dis Assoc Disord 2005;19:1-7

Examples of Brief Cognitive Assessment/Screening Tests

- Mini-Mental State Examination (MMSE)
- AD8
- Montreal Cognitive Assessment (MOCA)
- Self-Administered Gerocognitive Examination (SAGE) and BrainTest digital SAGE for tablet use



ORIENTATION: Answers must be precisely correct.

What is today's date?	Date	9th	1
What year is it?	Year	2001	1
What month is it?	Month	July	1
What day of the week is it?	Day	Monday	1
What season is it?	Season	Summer	1
What is the name of this clinic?	Clinic (Hospital)	Ohio State	1
What floor are we on?	Floor	1st	1
What city are we in?	City	Columbus	1
What county are we in?	County	Delaware Franklin	~~0~~ 1
What state are we in?	State	Ohio	

REGISTRATION: I will tell you 3 words to remember: ball, flag, and tree. Can you say them? [illegible]

	Ball	Ball	1
	Flag	Flag	1
	Tree	Tree	1

ATTENTION AND CALCULATION: [illegible]

93	D	93	1
86	L	86	1
79	R	79	1
72	O	72	1

RECALL: What were the 3 words I asked you to remember?

	Ball		0
	Flag		0
	Tree		0

LANGUAGE

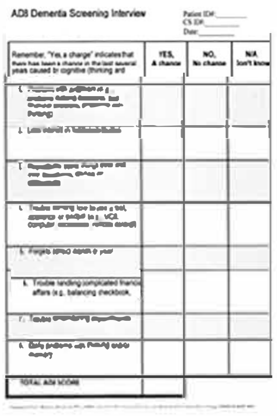
What is this called?	Pencil	ok	1
What is this called?	Watch	ok	1
Repeat the phrase:	No ifs, ands or buts	ok	1
Listen, then follow these instructions:	Take this paper in your right hand,	took L	0
[3 step command]	fold it in half,	ok	1
	and put it in your lap	OK	1
Do what this says:	CLOSE YOUR EYES	ok	1
Make up a sentence and write it:	Sentence (subject and verb)	ok	1
CONSTRUCTION: Copy the design.	Copy must have 10 angles with 2 intersecting.		
	Copy design	X	0

TOTAL: 25/30

MMSE

Folstein et al. J Psychiat Res 1975;12: 189-98

AD8



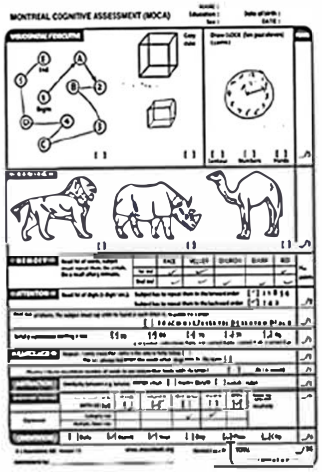
AD8 Dementia Screening Interview

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	YES, A change	NO, No change	N/A, Don't know
1. [illegible]			
2. [illegible]			
3. [illegible]			
4. [illegible]			
5. [illegible]			
6. Trouble handling complicated financ affairs (e.g., balancing checkbook,			
7. [illegible]			
8. [illegible]			
TOTAL AD8 SCORE			

Galvin et al. Neurology 2006;67:1942-1948

MOCA

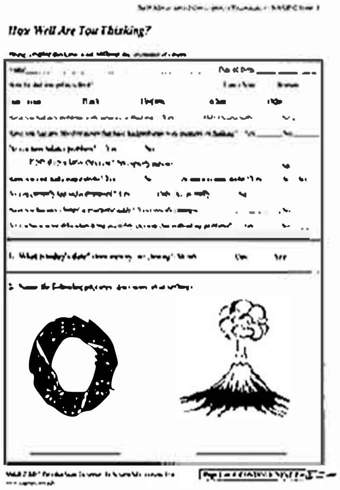


MONTREAL COGNITIVE ASSESSMENT (MOCA)

Nasreddine et al. J
Am Geriatr Soc
2005;53:695-699

SAGE

Page 1



How Well Are You Thinking?

Scharre et al. Alzheimer
Dis Assoc Disord 2009
at sagetest.osu.edu

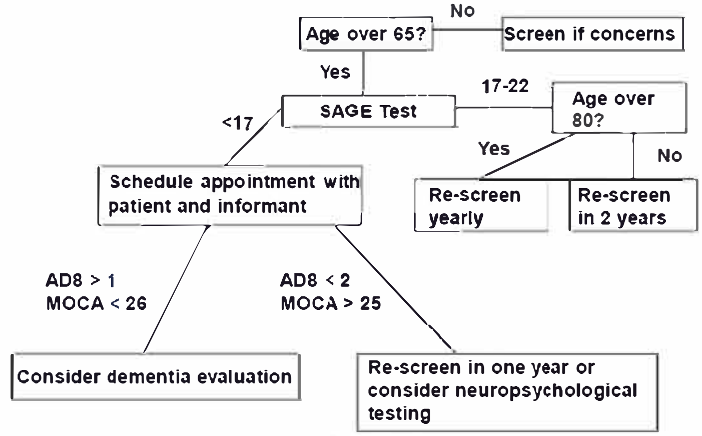
Self-Administered Gerocognitive Exam (SAGE)

- Score: 0 (worst) - 22 (best)
- Tests orientation, memory, language, visuospatial, and executive functioning
- Self-administered, easy to use
- Takes 10 to 15 minutes; needs no examiner
- Free download for individual or educational use: sagetest.osu.edu
- Now being used across the US and in many countries
- Over one million downloads the first 6 months of 2014

Self-Administered Gerocognitive Exam (SAGE)

- ❖SAGE scores were stable over time for those who did not convert to dementia
- ❖Changes in SAGE scores occurred 6 months earlier than changes in MMSE scores
- ❖The ease of repetitively giving the self-administered SAGE and identification of score stability or decline may provide clinicians significant diagnostic assistance
- ❖SAGE is now available for digital use on a tablet via the BrainTest app or BrainTest website

Staged Screening Approach



Age over 65?

No

Screen if concerns

Yes

SAGE Test

17-22

Age over 80?

Yes

No

Re-screen yearly

Re-screen in 2 years

<17

Schedule appointment with patient and informant

AD8 > 1
MOCA < 26

AD8 < 2
MOCA > 25

Consider dementia evaluation

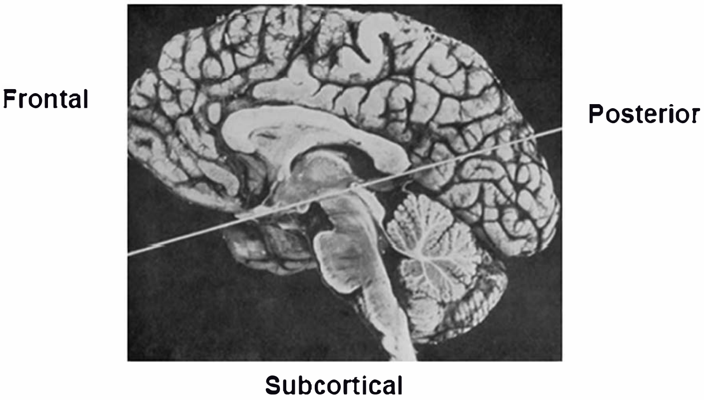
Re-screen in one year or consider neuropsychological testing

Scharre et al. Alzheimer Dis Assoc Disord 2010;24:64-71 at sagetest.osu.edu;
Galvin et al. Neurology 2006;67:1942-1948;
Nasreddine et al. J Am Geriatr Soc 2005;53:695-699

Dementia Related Behaviors

- Poor insight, apathy
- 70% - delusions of theft, harm, unwelcome visitors
- 60% - irritability, suspiciousness, agitation, aggression
- 45% - restlessness or wandering
- 40% - sleep disturbance
- 40% - dysphoria

Behavioral and Psychiatric Symptoms



Behavioral and Psychiatric Symptoms

Frontal Personality

- Apathy
- Irritability/agitation
- Self-absorption
- Sleep disturbance
- Eating disturbance
- Obsessive-compulsive / perseveration
- Aberrant motor behaviors
- Disinhibition
- Mood lability
- Intrusiveness
- Euphoria/mania
- Hypersexuality

Behavioral and Psychiatric Symptoms

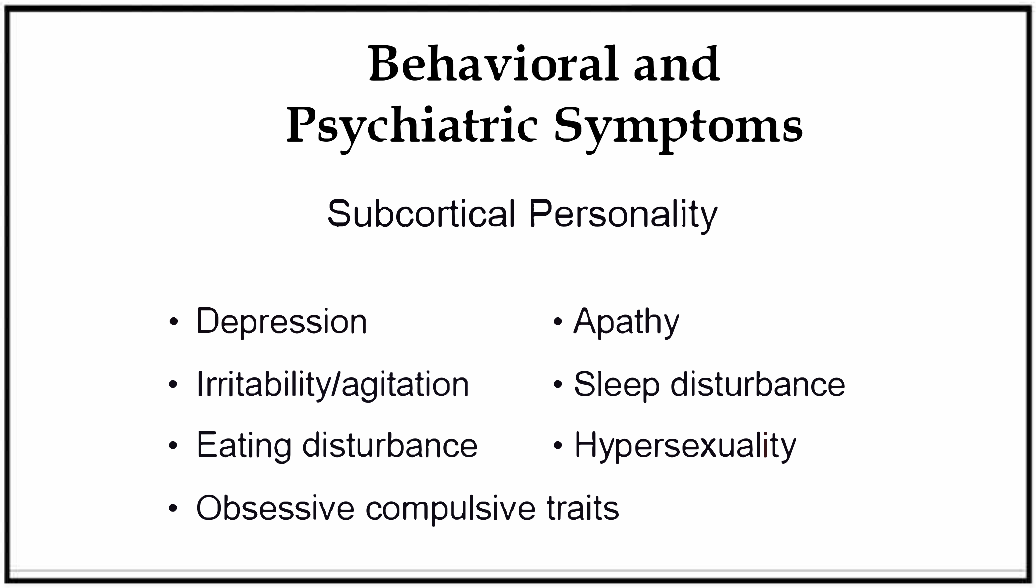
Posterior Personality

Temporal lobe

- Irritability/agitation
- Psychosis
- Visual and auditory hallucinations
- Anxiety
- Hypersexuality

Parietal-occipital lobe

- Delusions
- Visual hallucinations (common in DLB)
- Disengagement



Behavioral and Psychiatric Symptoms

Subcortical Personality

- Depression
- Irritability/agitation
- Eating disturbance
- Obsessive compulsive traits
- Apathy
- Sleep disturbance
- Hypersexuality

Behavioral Symptoms

Frontal: •FTD •AD

Posterior: •AD

Subcortical: •Depression •NPH •Huntington's disease •Parkinson's disease dementia

Mixed or any pattern: •Vascular dementia •Dementia with Lewy bodies •Rapidly evolving dementias

AD = Alzheimer's disease; FTD = Frontotemporal dementia; NPH = Normal pressure hydrocephalus

Laboratory Evaluation

Recommended for all dementias

- CBC
- Electrolytes, calcium, glucose, BUN, creatinine, LFT
- B12, folate
- TSH, T4
- FTA

Optional Evaluations

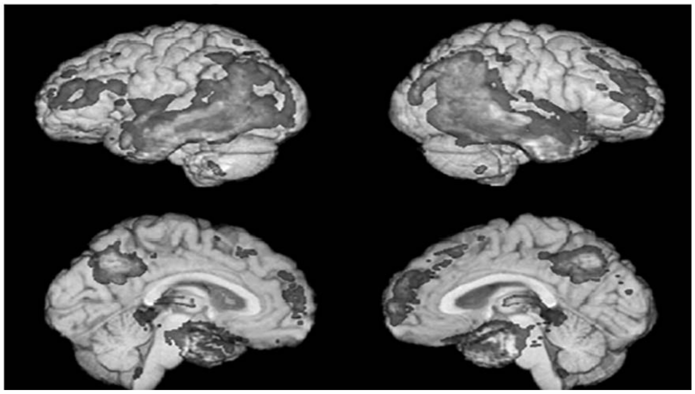
Consider for rapidly evolving dementias

- Sed rate, inflammatory markers
- HIV, Lyme
- CXR, EKG
- Urinalysis
- Assays for heavy metals, toxins
- LP
- EEG

Neuroimaging

- CT or MRI - neoplasms, abscesses, infarctions, white matter diseases, hydrocephalus, and subdural hematomas
- SPECT or PET - degenerative dementias

Gray Matter Reductions in AD Using Voxel Based Morphometry



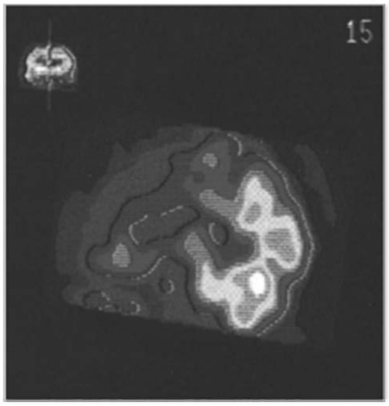
Alexander GE et al., ADNI MRI Core Team, 2007

Typical AD PET Scan

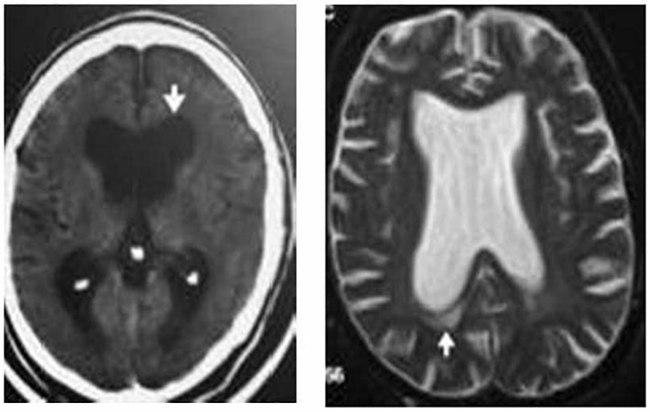
Normal Brain AD Brain

Provided courtesy of M. Mega, MD, PhD, Department of Neurology, UCLA School of Medicine.

FTD SPECT Scan

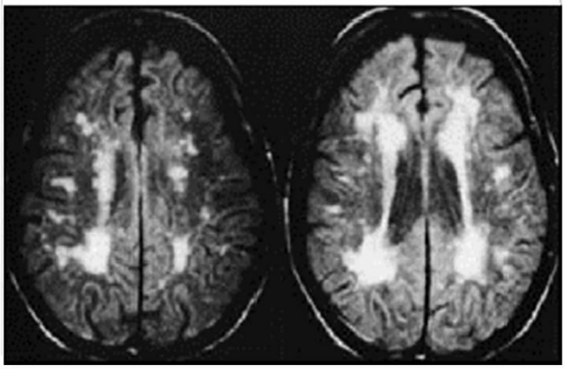


Normal Pressure Hydrocephalus



http://www.emedicinehealth.com/articles/39837-9.asp

Subcortical Vascular Dementia



Sachdev et al., Medical Journal of Australia 1999; 170: 81-85

Herpes Simplex Encephalitis

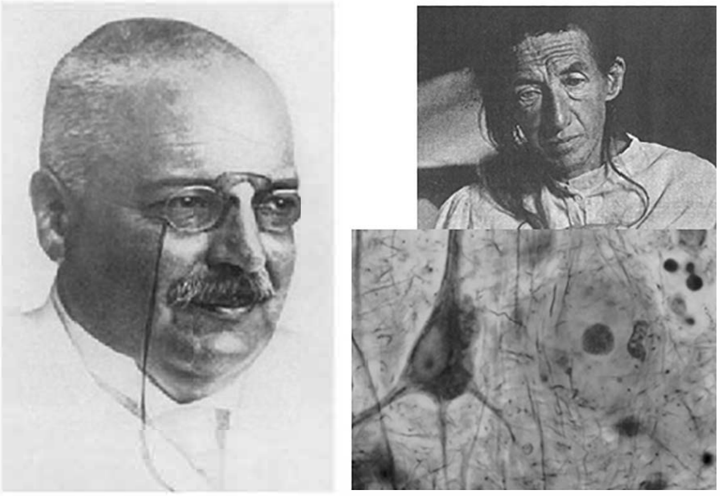
Dementia Type

Differential Diagnosis

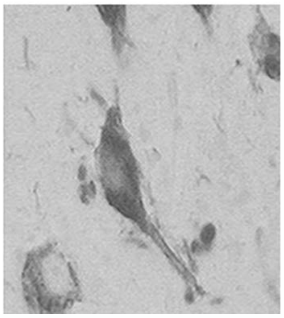
- Dementia syndromes fit specific patterns
- History: Onset (acute,subacute, insidious), Course (stepwise, progressive, static)
- Exam: Normal, apraxia only, movement / tone / gait abnormalities
- Mental status: Cortical, subcortical, mixed
- Laboratory and imaging also help to differentiate these conditions
- Never accept a diagnosis of dementia – ask the doctor to tell you the type of dementia

Alzheimer's Disease

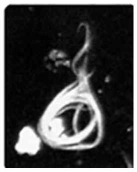
- Insidious onset, gradually progressive course
- Usually begins after 50
- Memory, language, visuospatial impairments early
- No remissions or plateaus
- Genetic cause is very common
- Death in 6 - 12 years after onset



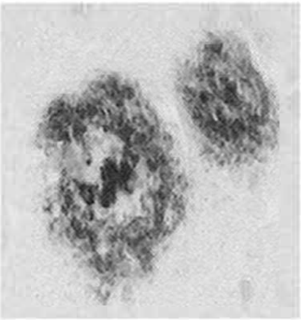
Neurofibrillary Tangles



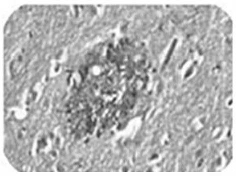
Immunocytochemical staining of **tau proteins** in neurofibrillary tangles in the cortex of an AD patient's brain



Senile Plaques



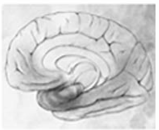
Immunocytochemical staining of **β-amyloid proteins** in senile plaques in the cortex of an AD patient's brain



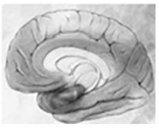
Neuropathology in AD

- 1st Stage - Hippocampal, temporal/parietal/occipital association cortex

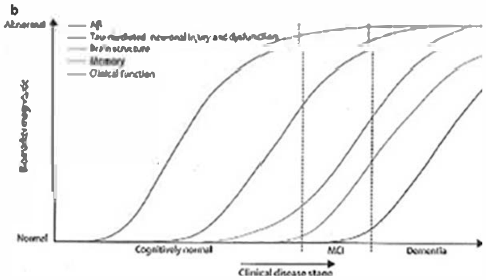
- 2nd Stage - Add frontal association cortex



- 3rd Stage - Expanding regional pathology; add basal ganglia



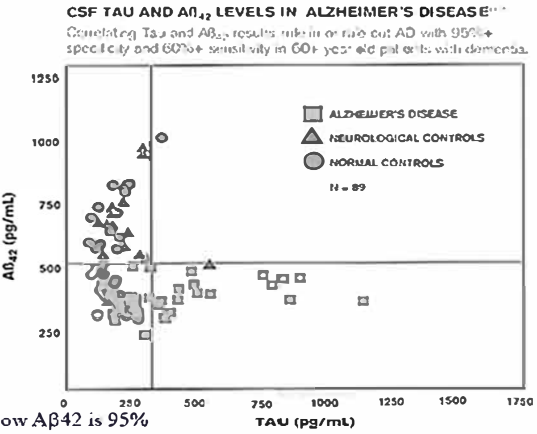
Biomarkers in AD



- Synaptic dysfunction (FDG-PET/fMRI)
- Tau-mediated neuronal injury (CSF)
- Brain structure (volumetric MRI)

Jack et al. Lancet Neurol 9:119-129, 2010; Trojanowski J, Shaw L. et al., ADNI Biomarker Core Team, 2011

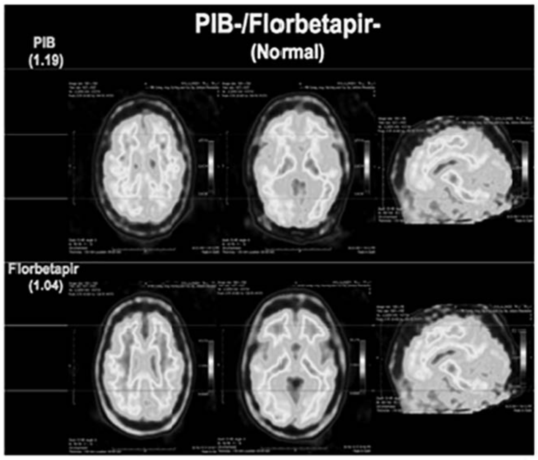
CSF AD Biomarkers



Elevated CSF tau and low Aβ42 is 95% specific and 60% sensitive for AD

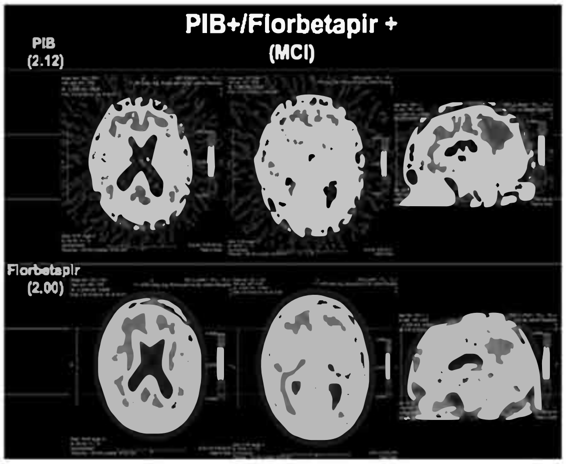
Motter et al. Ann Neurol 1995;38:643-48

Amyloid PET Imaging

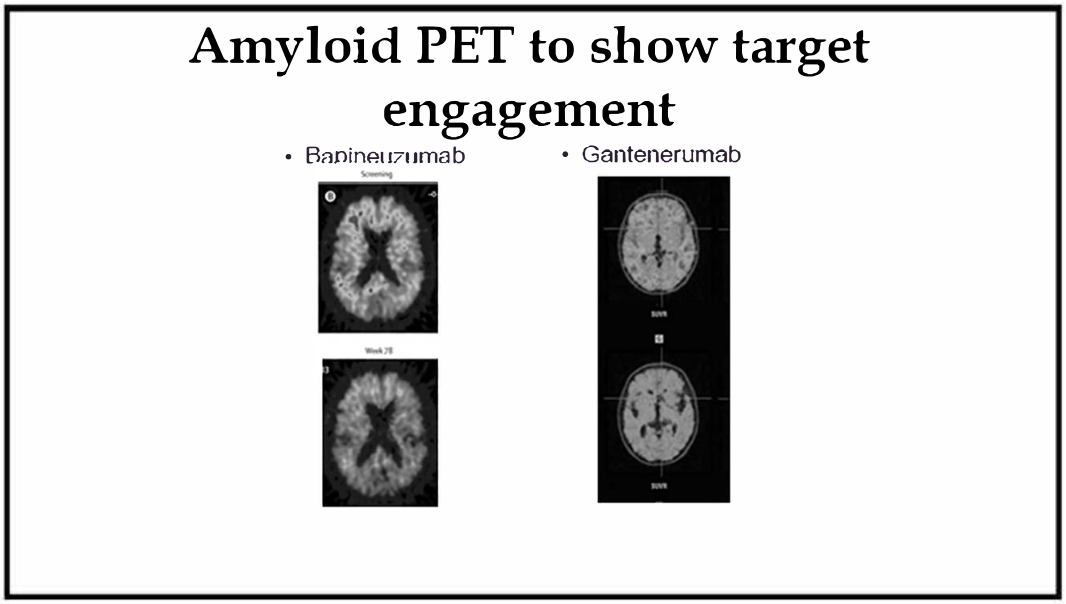


Jagust W. et al., ADNI-GO PET Core Team, 2011

Amyloid PET Imaging



Jagust W. et al., ADNI-GO PET Core Team, 2011



Amyloid PET to show target engagement

- Bapineuzumab
- Gantenerumab

AD Risk Factors

- Age
- Family history
- Down's syndrome: AD after about age 55
- Apolipoprotein E ε4
- Female gender
- Head trauma
- Hypertension
- Cardiovascular disease
- Cerebrovascular disease
- Hyperlipidemia

Andersen K et al. *Neurology.* 1999;53:1992-1997

Cognitive Rx in AD

Efficacy of Cholinesterase Inhibitors

- Donepezil (Aricept), Rivastigmine (Exelon), and Galantamine (Razadyne)
- All of them work
- Up to 80% of patients show no decline after 6 months of treatment; 50% no decline after 1 year
- Need to give for ≥ 12 months to determine utility
- Always titrate to highest dose
- Benefit lasts 6-10 years

Cognitive Rx in AD

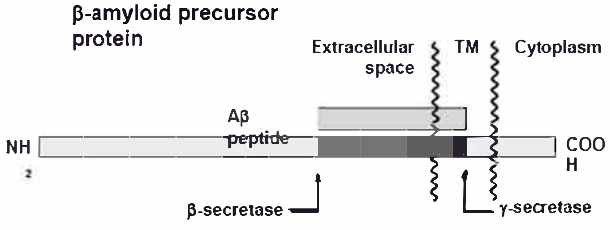
NMDA Antagonists: Memantine (Namenda)

- N-methyl-D-aspartate (NMDA) antagonists potentially prevent neuronal injury by reducing excitatory amino acid toxicity by glutamate
- Give in addition to cholinesterase inhibitor; moderate to severe AD
- Side effects include headache, dizziness, fatigue, confusion

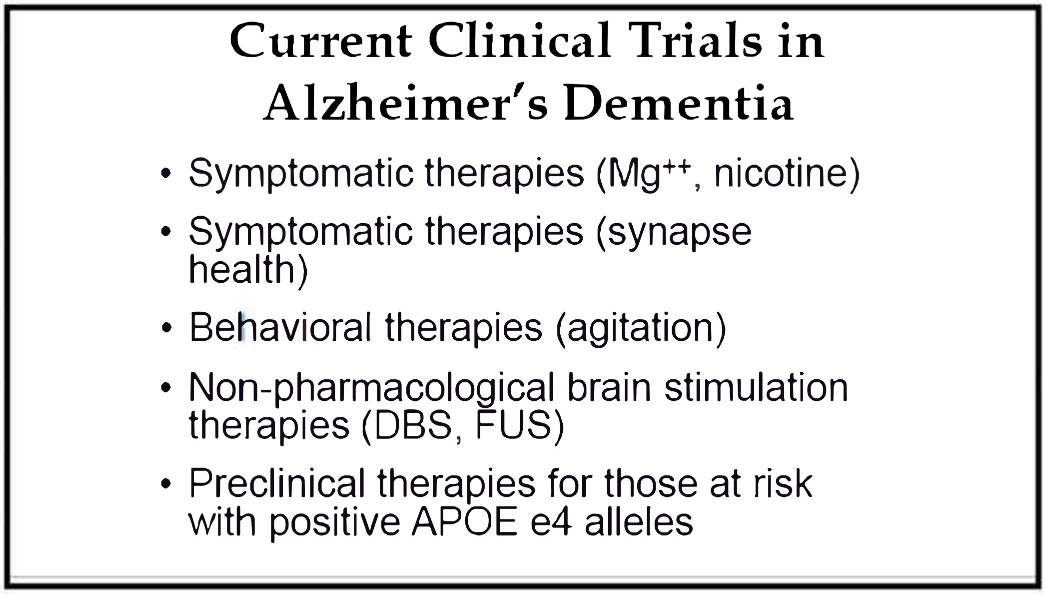
Current Clinical Trials in Alzheimer's Dementia

- ADNI: Neuroimaging and biomarkers
- Beta secretase inhibitors
- Monoclonal antibody against amyloid
- Combined drug treatments (Beta secretase inhibitors and monoclonal antibodies)
- Microtubular stabilizers (tau)

Proteolytic Cleavages of Amyloid Precursor Protein (APP) That Produce Aβ Peptide

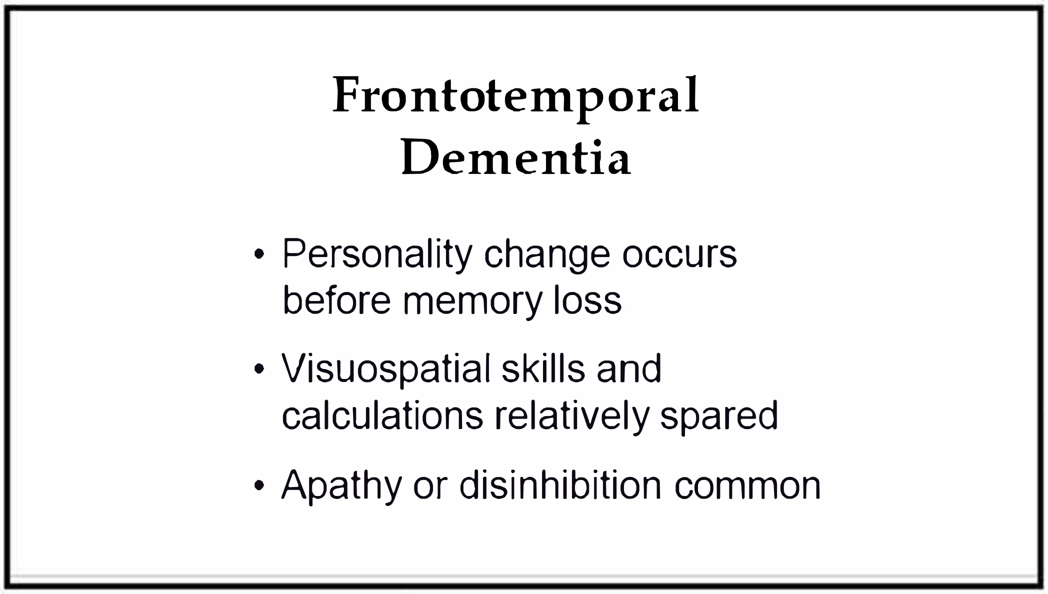


Selkoe DJ et al. *JAMA*. 2000;283:1615-1617.



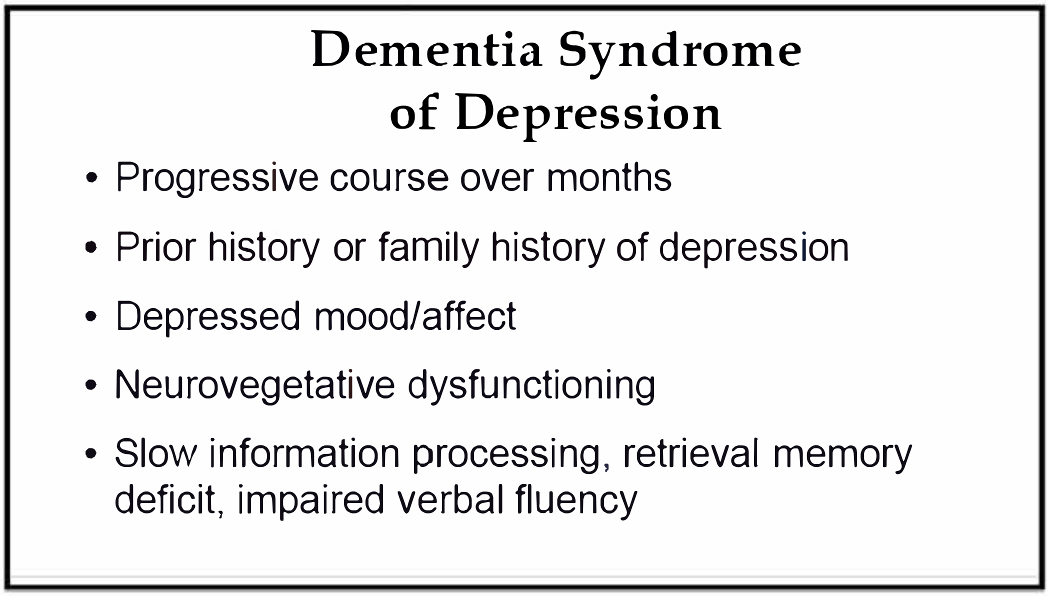
Current Clinical Trials in Alzheimer's Dementia

- Symptomatic therapies (Mg^{++}, nicotine)
- Symptomatic therapies (synapse health)
- Behavioral therapies (agitation)
- Non-pharmacological brain stimulation therapies (DBS, FUS)
- Preclinical therapies for those at risk with positive APOE e4 alleles



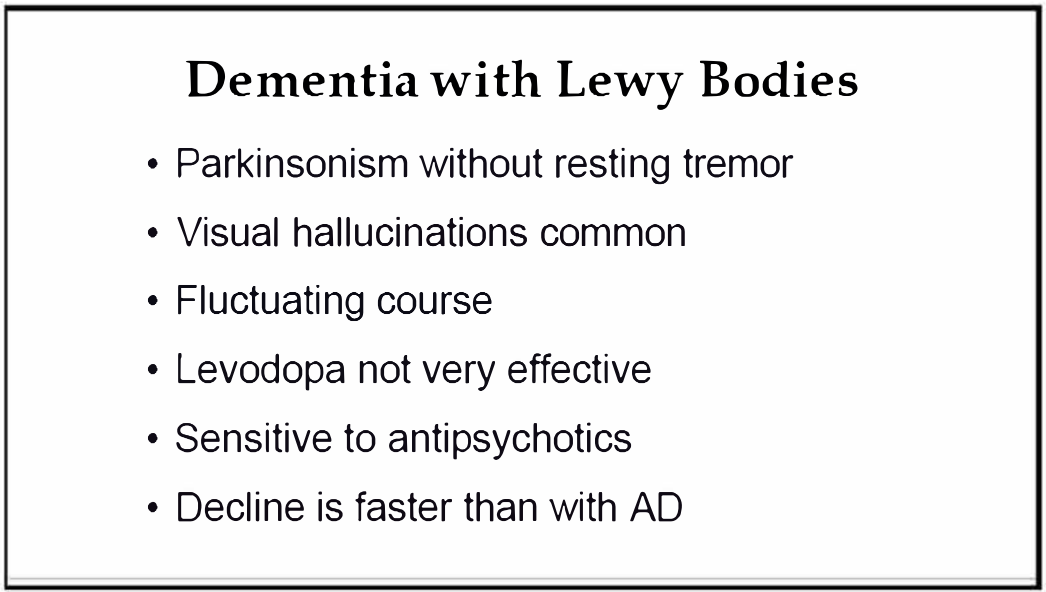
Frontotemporal Dementia

- Personality change occurs before memory loss
- Visuospatial skills and calculations relatively spared
- Apathy or disinhibition common



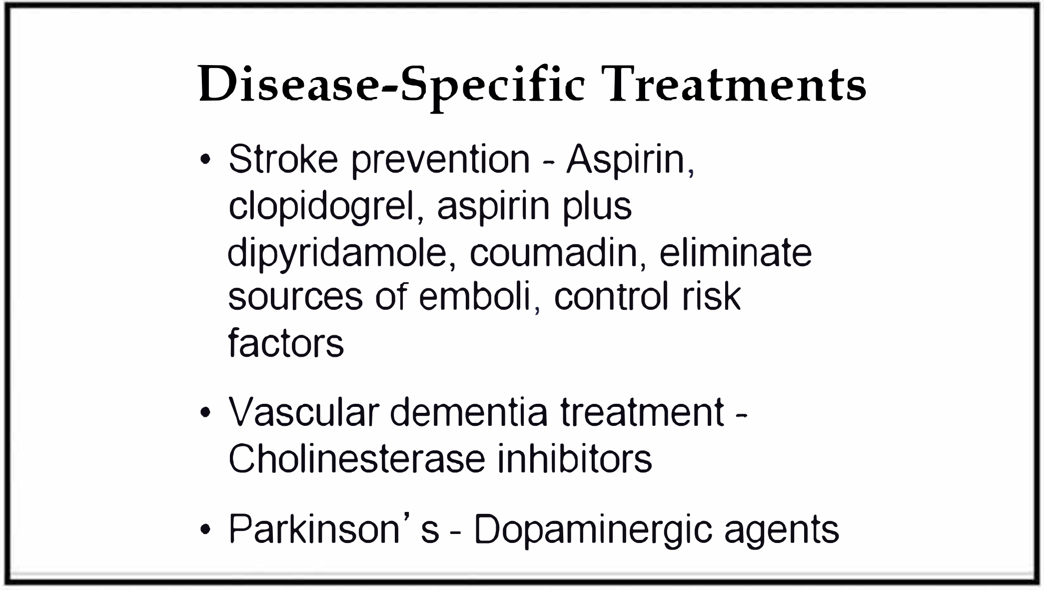
Dementia Syndrome of Depression

- Progressive course over months
- Prior history or family history of depression
- Depressed mood/affect
- Neurovegetative dysfunctioning
- Slow information processing, retrieval memory deficit, impaired verbal fluency



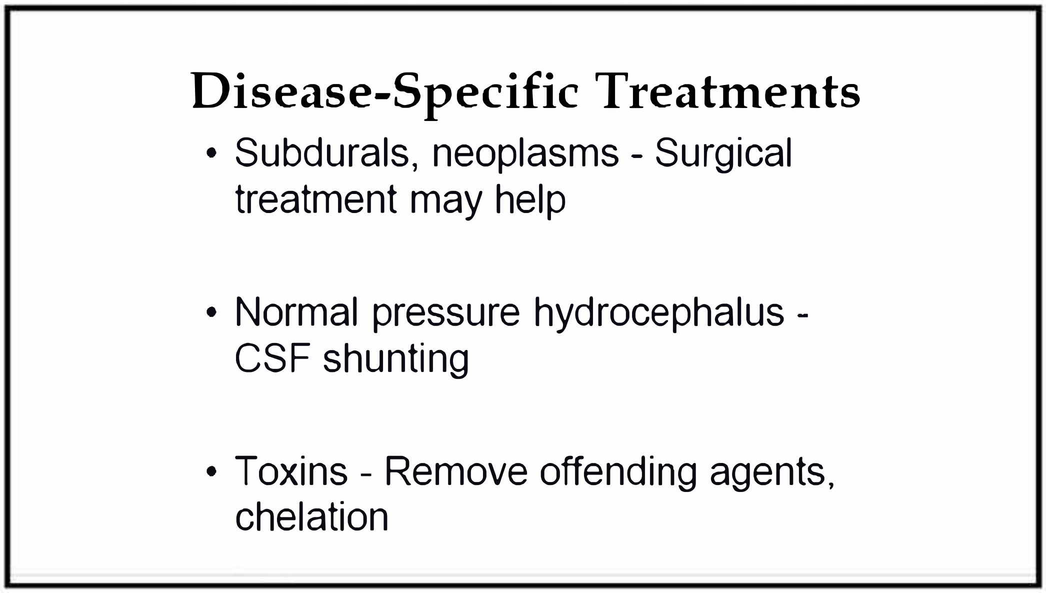
Dementia with Lewy Bodies

- Parkinsonism without resting tremor
- Visual hallucinations common
- Fluctuating course
- Levodopa not very effective
- Sensitive to antipsychotics
- Decline is faster than with AD



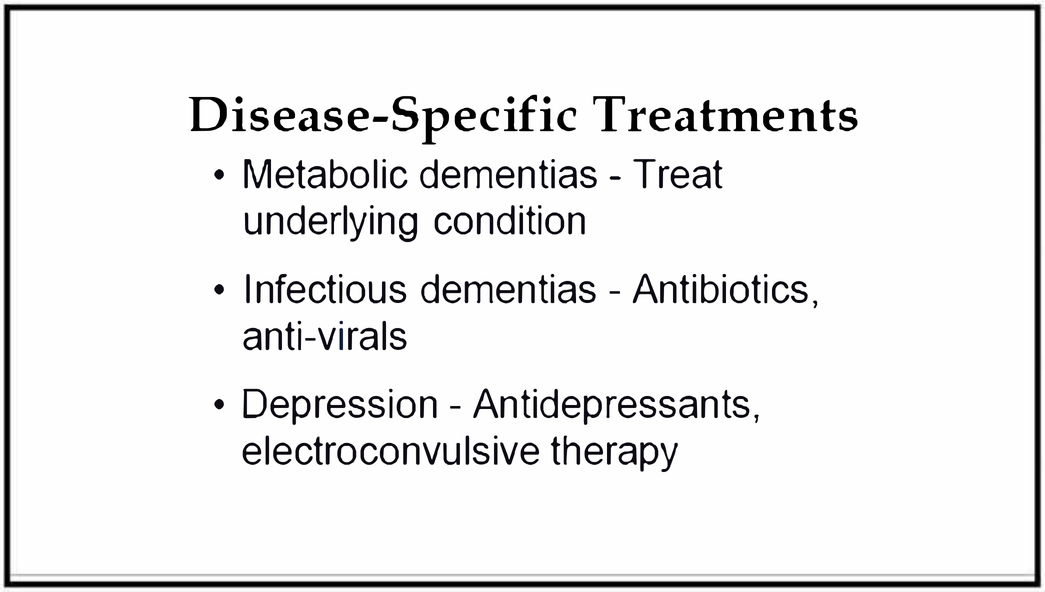
Disease-Specific Treatments

- Stroke prevention - Aspirin, clopidogrel, aspirin plus dipyridamole, coumadin, eliminate sources of emboli, control risk factors
- Vascular dementia treatment - Cholinesterase inhibitors
- Parkinson’ s - Dopaminergic agents



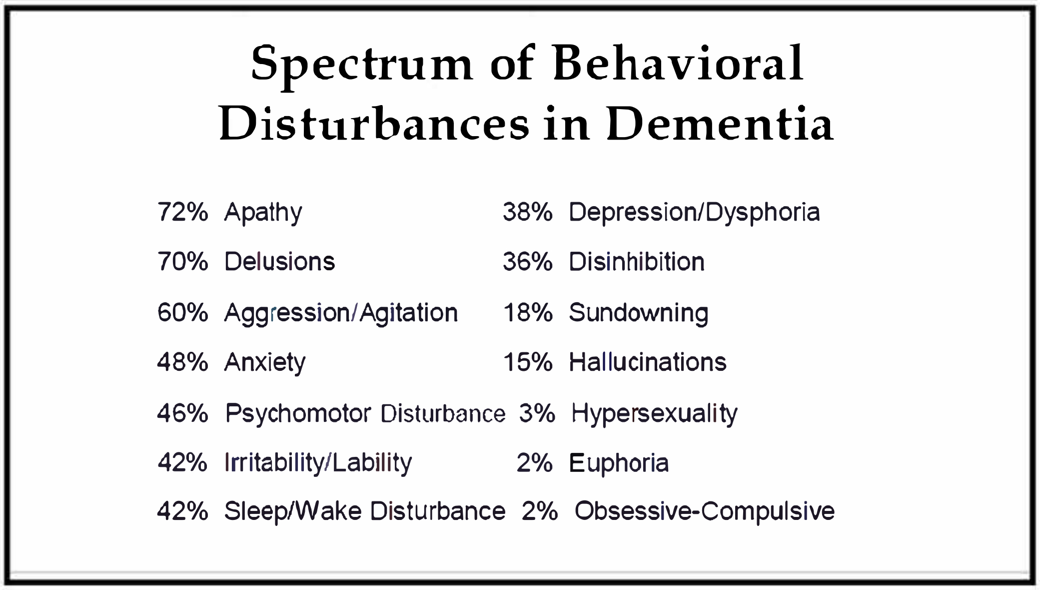
Disease-Specific Treatments

- Subdurals, neoplasms - Surgical treatment may help
- Normal pressure hydrocephalus - CSF shunting
- Toxins - Remove offending agents, chelation



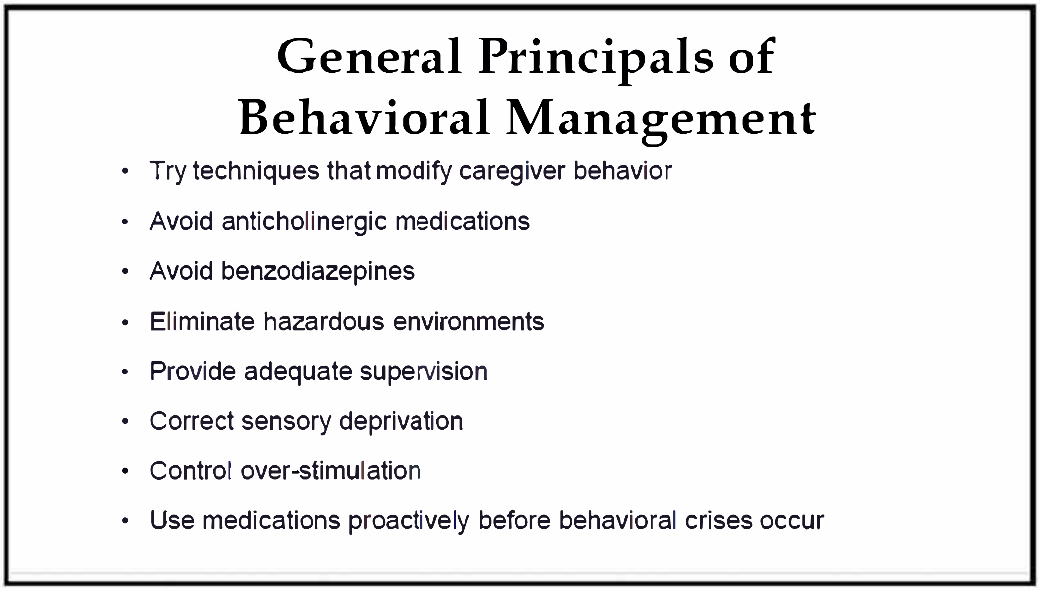
Disease-Specific Treatments

- Metabolic dementias - Treat underlying condition
- Infectious dementias - Antibiotics, anti-virals
- Depression - Antidepressants, electroconvulsive therapy



Spectrum of Behavioral Disturbances in Dementia

72%	Apathy	38%	Depression/Dysphoria
70%	Delusions	36%	Disinhibition
60%	Aggression/Agitation	18%	Sundowning
48%	Anxiety	15%	Hallucinations
46%	Psychomotor Disturbance	3%	Hypersexuality
42%	Irritability/Lability	2%	Euphoria
42%	Sleep/Wake Disturbance	2%	Obsessive-Compulsive



General Principals of Behavioral Management

- Try techniques that modify caregiver behavior
- Avoid anticholinergic medications
- Avoid benzodiazepines
- Eliminate hazardous environments
- Provide adequate supervision
- Correct sensory deprivation
- Control over-stimulation
- Use medications proactively before behavioral crises occur

Changes in Behavior: Always Consider

- Check for infection and dehydration
- Evaluate for changes in medical conditions
- Watch for adverse medication effects: Stop or adjust any new medication added

- Assist with pain management
- Environmental modification for reactive agitation
- **Avoid** ER/hospital for behavioral disturbances
- In hospital setting: get a sitter to reassure, calm, redirect - behavioral modification

General Principals of Behavior Pharmacotherapy

- Dementia, a disorder of the brain, results in brain cell damage leading to behavioral disturbances -- All behaviors arise in the brain
- If the behavioral disturbance is not bothersome to the patient or caregivers, no medication is necessary
- If the behavioral disturbance is bothersome to the patient or caregivers, use of medications that work in the brain improve quality of life
- Use of any medication – balance risk & benefit

Behavior Pharmacotherapy

- Behavioral drug use in dementia is off-label
- Behavioral medications including antipsychotics with their black box warnings, are safe when used appropriately (low doses)
- Treat specific underlying behaviors
- Patients may have several behaviors that are best treated with different medications
- Use low doses, go slow, but go
- Avoid as needed behavioral medications
- If behaviors go away, taper down or off

Agitation/Aggression

- Reactive
- Due to psychosis, delusions
- Due to restlessness, wanting to go
- Due to anxiety, fear
- Due to intrusiveness, disinhibition
- Due to possessiveness

Preferred Approaches for Agitation/Aggression in Dementia

With psychotic and delusional features

1. Quetiapine, ziprasidone, risperidone, olanzapine, clozapine

With restlessness and wanting to go

1. Divalproex sodium
2. Citalopram and other SSRI antidepressants

Preferred Approaches for Agitation/Aggression in Dementia

With anxiety or depression

1. SSRI antidepressants
2. Divalproex sodium

With intrusiveness or disinhibition

1. Divalproex sodium
2. SSRI antidepressants

Summary

- Dementia syndromes fit specific patterns
- Mental status / cognitive testing can help sort between cortical, subcortical and mixed impairments
- Combining history, physical findings, cognitive testing, behavioral features, neuroimaging, and laboratory can make diagnosis more clear
- Most dementia conditions are treatable including behaviors

OSU Memory Disorders Research Center

OSU Memory Disorders Research Center
Fitting the Pieces Together

Douglas W. Scharre, MD	Maria Kataki, MD, PhD
Rawan Tarawneh, MD	Arun Ramamurthy, MD
Renee Kovesci, MS, CNP	Jessica Truelove, CNP
Barbara Eason Himes, PhD	Rebecca Davis, RN, MSW, LISW
Jennifer Icenhour, BA, CCRC	Nicole Vrettos, BS, CCRC
Brooke Eiginger, BA	Ashley Garcia, BS
Areej Tariq, MBBS	Kristina Rawson, BA
Breanna Henry, BA	Haikady N. Nagaraja, PhD

How Well Are You Thinking?

Please complete this form in ink **without** the assistance of others.

Name____ Date of Birth ______/______/______

How far did you get in school? __________________________________ I am a Man______ Woman______

I am Asian_________ Black_________ Hispanic_________ White__________ Other_________

Have you had any problems with memory or thinking? Yes______ Only Occasionally_______ No______

Have you had any blood relatives that have had problems with memory or thinking? Yes______ No______

Do you have balance problems? Yes________ No________

If yes, do you know the cause? Yes (specify reason)______________________________ No__________

Have you ever had a major stroke? Yes_______ No_______A minor or mini-stroke? Yes______ No______

Do you currently feel sad or depressed? Yes_________ Only Occasionally_________ No_________

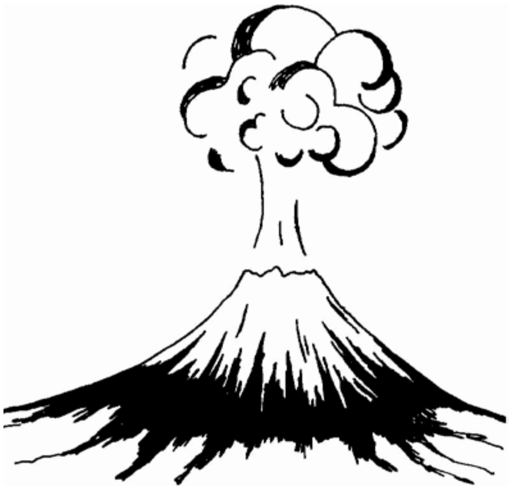
Have you had any change in your personality? Yes (specify changes)______________________ No______

Do you have more difficulties doing everyday activities due to thinking problems? Yes_______No_______

1. **What is today's date?** (from memory – no cheating!) Month__________ Date_______ Year_________

2. **Name the following pictures** (don't worry about spelling):

____



____

CONTINUE NEXT PAGE

Answer these questions:

3. How are a watch and a ruler similar? Write down how they are alike. They both are… what?

____

4. How many nickels are in 60 cents? ___________________________

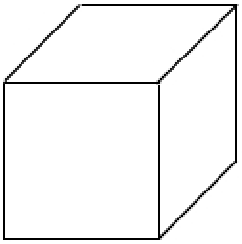
5. You are buying $13.45 of groceries. How much change would you receive back from a $20 bill?

____

6. Memory Test (memorize these instructions). Do later only after completing this entire test:

At the bottom of the very last page: Write "I am done" on the blank line provided

7. Copy this picture:



8. Drawing test

- Draw a large face of a clock and place in the numbers
- Position the hands for 5 minutes after 11 o'clock
- On your clock, label "L" for the long hand and "S" for the short hand

CONTINUE NEXT PAGE

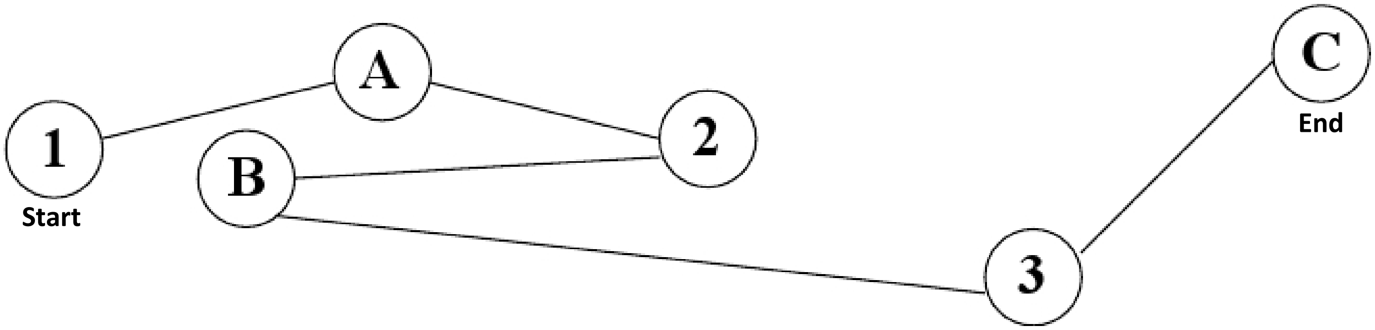
9. Write down the names of 12 different animals (don’t worry about spelling):

________________ ________________ ________________ ________________

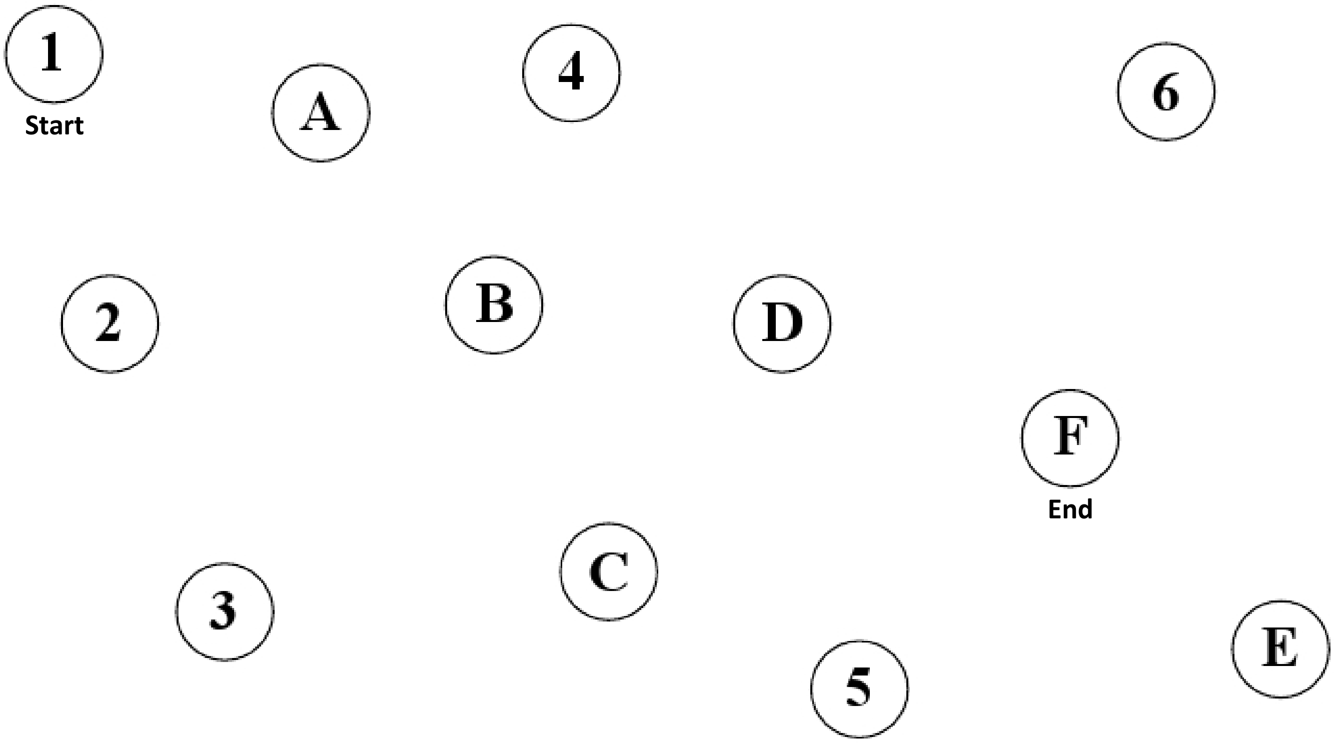
________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

Review this example (this first one is done for you) then go to question 10 below: Draw a line from one circle to another starting at 1 and alternating numbers and letters (1 to A to 2 to B to 3 to C).



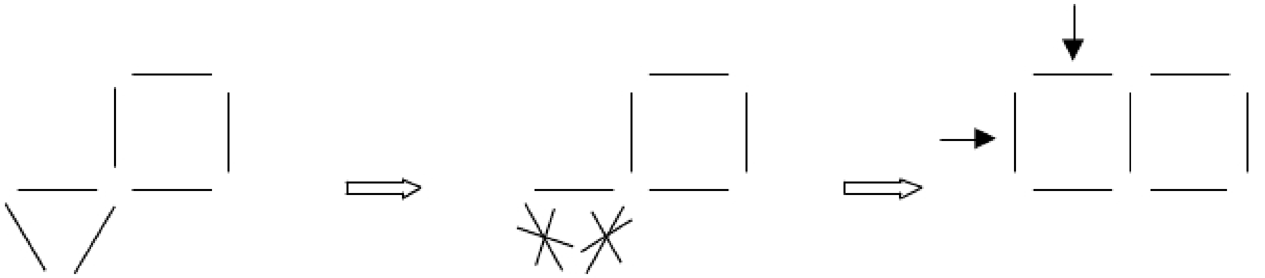
10. Do the following: Draw a line from one circle to another starting at 1 and alternating numbers and letters in order before ending at F (1 to A to 2 to B and so on).



CONTINUE NEXT PAGE

Review this <u>example</u> (this first one is done for you) then answer question 11 below:

- Beginning with 1 triangle and 1 square
- Move 2 lines (marked with an X)
- To make 2 squares and no triangle
- Each line must be part of a complete square (no extra lines).



Put them here (at arrows)

1 triangle, 1 square

(Example)

Move these 2 lines

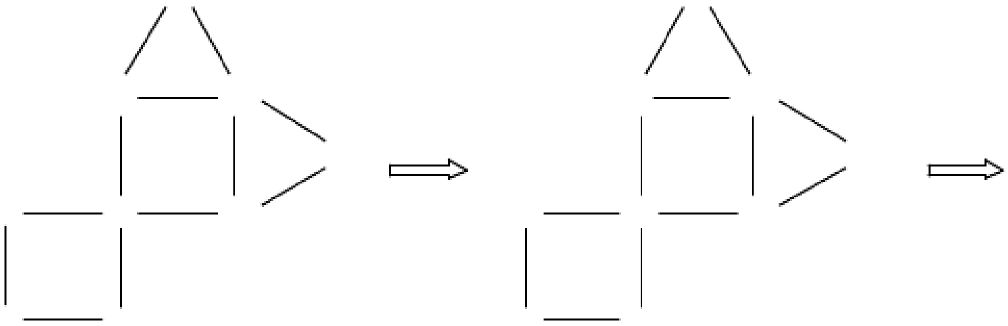
(Example)

Make 2 squares (answer)

(Example)

11. Solve the following problem:

- Beginning with 2 squares and 2 triangles
- Move 4 lines (mark with an X)
- To make 4 squares and no triangles
- Each line must be part of a complete square (no extra lines).



2 squares, 2 triangles

Move 4 lines

Mark with an X

Draw answer here

4 squares

12. Have you finished? ___________________________________

STOP

Douglas W. Scharre, Scharre.1@osu.edu, (614) 293-4969

This instrument cannot substitute for medical advice, diagnosis or treatment by a trained medical professional. Diagnosis and treatment of human illness should be based collectively on medical history, including family medical history, and a physical examination along with a doctor's professional judgment and review of all test results. The material contained in this instrument does not contain standards that are meant to be applied rigidly and followed in virtually all cases. Physicians' judgment must remain central to the selection of diagnostic tests and therapy options of a specific patient's medical condition.

Responding to Common Challenges in Caring for Someone with Dementia in Ways that Create a Supportive Environment

Paula M. Taliaferro, MGS, LSW
Central Ohio Area Agency on Aging

Responding to Common Challenges in Caring for Someone With Dementia

Paula M. Taliaferro, MGS, LSW

Outline

1. Dementia: What Can Change And What Remains Intact?
2. What Is Success?
3. Pay Attention To......
4. Always Use......
5. Getting Appropriate Care

Dementia:
Can Involve Changes IN:

- Short Term Memory(Getting Lost in Time & Space)
- Body Sensations(Hypersensitivity in 4 areas)
- Vision(Binocular or Monocular Vision)
- Thinking & Sensing-Hallucinations & Delusions

Dementia: Can Involve Changes IN:

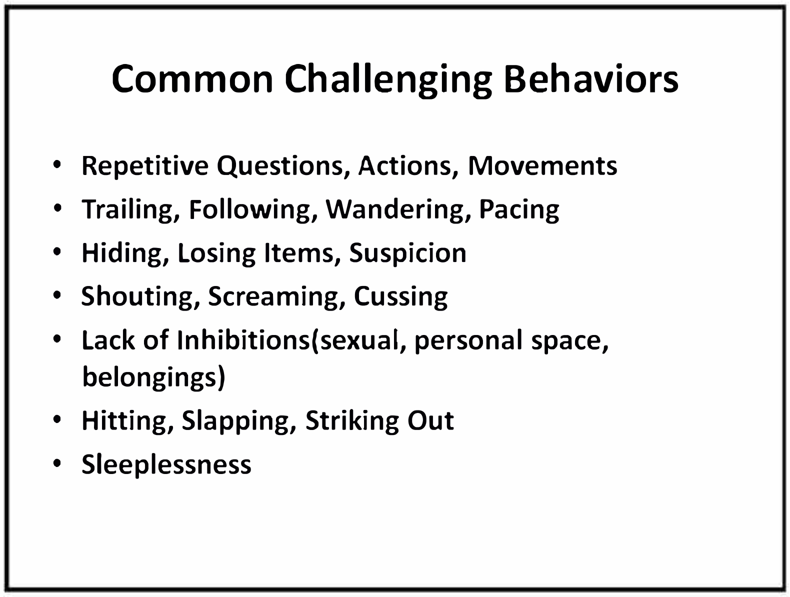
- Language and Speech Recognition
- Emotions(Volatility)
- Safety Awareness(Disappears)
- Initiating Actions, Decision Making, Judgement, Problem Solving
- Insight—Awareness that there is a problem.

Dementia: What Remains Intact?

- Automatic Social Responses(chitchat, greetings, handshakes)
- Long Term Memories & Skills(learned early in life)
- Response to Fearful Situations--Fight, Flight, Freeze when scared or startled!

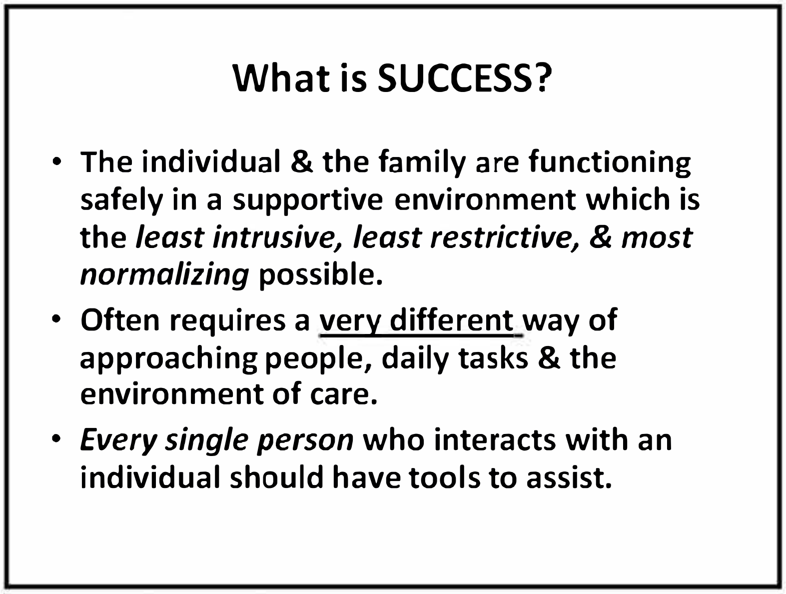
Dementia: What Remains Intact?

- Memories of ugly language, cuss words, personal observations about others(can be rude or unkind)
- Sense of curiosity/wonder/awe
- Desire to Remain in Control-be an adult
- Music *and* Rhythm



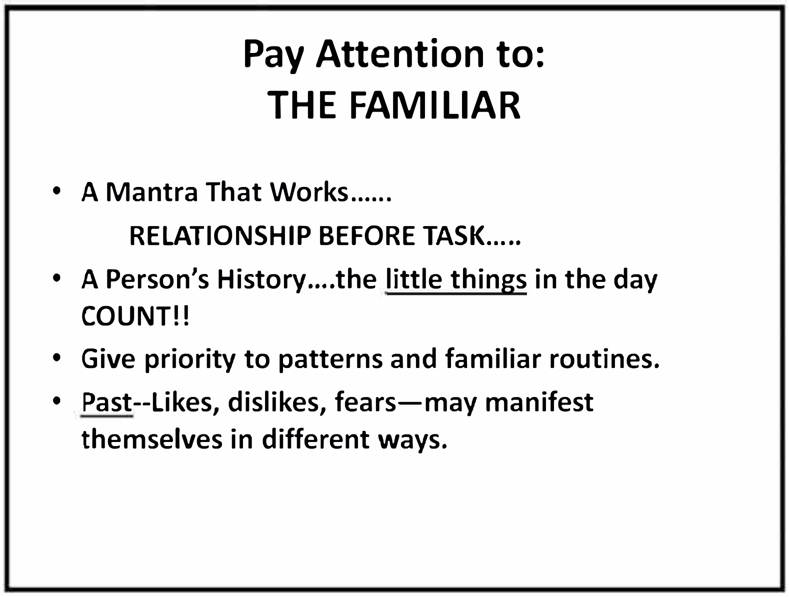
Common Challenging Behaviors

- Repetitive Questions, Actions, Movements
- Trailing, Following, Wandering, Pacing
- Hiding, Losing Items, Suspicion
- Shouting, Screaming, Cussing
- Lack of Inhibitions(sexual, personal space, belongings)
- Hitting, Slapping, Striking Out
- Sleeplessness



What is SUCCESS?

- The individual & the family are functioning safely in a supportive environment which is the *least intrusive, least restrictive, & most normalizing* possible.
- Often requires a very different way of approaching people, daily tasks & the environment of care.
- *Every single person* who interacts with an individual should have tools to assist.



Pay Attention to:
THE FAMILIAR

- A Mantra That Works……

  RELATIONSHIP BEFORE TASK…..
- A Person's History….the little things in the day COUNT!!
- Give priority to patterns and familiar routines.
- Past--Likes, dislikes, fears—may manifest themselves in different ways.

Pay Attention to:
DAILY ACTIVITIES

- People need to *feel useful—* That their presence matters—that they are helping somehow….
- Pay great attention to *appropriate sensory stimulation*…..not too much or too little. Crowds—even family can be overwhelming.
- Pay Attention To *WARMTH*—especially shoulders, hands and feet

Pay Attention to:
DAILY ACTIVITIES

- Walking & Moving Activities…..sooo important….
- Music, Music, Music(incorporate often and in many forms)
- Dancing, Dancing, Dancing(or activities with elements of dance in them)
- Hand Massage—And other forms of TOUCH
- Activities with color, art, or textures in them

Pay Attention to:
DAILY ACTIVITIES

- Readily accessible boxes filled with familiar Items/Pictures
- Opportunities to Sort and Rearrange, Repetitive Movement
- Real Animals or Lifelike Stuffed Animals(i.e. Memorable Pets, Sootheze Pets)
- Simulated Presence Therapy (recordings of voices or videos of familiar people, sounds, songs, old movies)

Familiar Items to Arrange

- Feather Dusters
- Jewelry Box
- Silverware
- Tools—Toolbox
- Paint Swatches/Chips
- Puzzles with larger pieces(36-64)
- Towels/Foldable Items
- Dolls
- Tupperware
- Pocketbook
- Shoe Shine Box
- Musical Instruments
- Ads/Coupons
- Cards/Dominos

Pay Attention to:
VISUAL CUES

- Your Facial Expressions & Your Head Motions.
- Your Movements-People Will *Mimic* Actions.
- Avoid a confrontational stance & finger pointing.
- What visual cues are in the environment?
- Match Visual Cues to Vocal and Touch Cues—***crucially important***.

Pay Attention to:
VOCAL CUES

- Avoid “Parent Voice”
- Avoid high sing/song pitch.
- Avoid anything resembling the “royal we.”
- Use conversational mode BUT make requests SHORT AND SWEET.
- Ask don’t Tell. “Do me a favor”, “Would You Mind,” “Tell You What, I Need”
- Say I’m sorry frequently—”I’m sorry I made you angry,” “I’m sorry, this is hard,” “I’m sorry, I embarrassed you”

Pay Attention to:
THE ORDER OF TASKS
…..SEQUENCING

- Go Brush Your Teeth…..How many steps?
- Think though tasks to the "hidden assumptions"—crucially important
- Identify what parts of sequence are still available to the person…
- Model behaviors & movements
- Use correct visual cues

Pay Attention To:
HOW YOU ASSIST A PERSON

Helpful Tips:

- Come from the *front*-always in visual range
- Use touch with care—do not touch people in personal space without warning
- Always assist from the person's *Dominant Side*
- Go SLOW—Stay CALM and CHEERFUL
- BE ALERT, watch and listen carefully

Always Use:
POSITIVE PHYSICAL APPROACH™

1. Come from the FRONT—ALWAYS!!
2. Go SLOW.
3. Pause at the EDGE of Public Space(vs. Personal or Intimate space).
4. Offer Your HAND in a handshake.
5. Get to the SIDE-The person's *DOMINANT* side.
6. Get LOW-Match eye level.
7. Use the person's NAME(which name?)
8. Wait for a Welcoming RESPONSE—IE. permission to move closer.

Always Use:
HAND UNDER HAND™ CONTACT

- Offer your hand to the person's dominant hand.
- Slide your hand around so that the thumbs are encircling and the person's hand is on TOP of yours.
- Use this stance to exert light palm pressure-which can be calming.
  - Use this stance to gauge a person's response to touch.
  - Use this stance to establish safe physical boundaries.
  - Use this stance to guide hand and arm movement.

www.youtube.com/user/teepasnow

SUGGESTIONS for Using Hand Under Hand™ Contact

- Hygiene
- Eating
- Dressing
- Walking/Guiding

Getting Appropriate Care

- **WATCH, WATCH, WATCH what is happening with your individual and those who are assisting him/her.**
- **Attend ALL care conferences and bring up concerns to those responsible for staff.**
- **You are an ADVOCATE for the person so do not hesitate to make suggestions.**
- **Put serious concerns IN WRITING to the administrator.**

What is SUCCESS?

- **The individual & the family are functioning *safely* in a supportive environment which is the *least intrusive, least restrictive, & most normalizing* possible.**
- **Often requires a very different way of approaching people, daily tasks & the environment of care.**
- ***Every single person* who interacts with an individual should have tools to assist.**

Helpful Resources

Challenging Behaviors in Dementia

- *Teepa Snow's Positive Approach to Care YouTube Channel:* www.youtube.com/user/teepasnow
- *Building Advanced Skills in Dementia Caregiving(2012) & The Senior Gems(2013),* Also other Presentations by Teepa Snow, Available along with other video and pdf materials from www.teepasnow.com and www.pinesofsarasota.com.
- Morningside Ministries www.mmlearn.org, has many videos and materials available from the website and the You Tube channel.
- *The 36 Hour Day: A Family Guide to People who have Alzheimer's Disease, other Dementias and Memory Loss* by Nancy Mace and Peter Rabins. 6th Ed. 2017.
- *The Best Friends Approach to Alzheimer's Care.* By Virginia Bell and David Troxel. 1997.
- *Learning to Speak Alzheimer's* by Joanne Koenig Coste. 2004
- *Bathing without a Battle, 2nd Edition.* Edited by A Barrick & J. Rader. 2008. Also has a helpful website and video. www.bathingwithoutabattle.unc.edu.
- *Dementia Beyond the Drugs: Changing the Culture of Care* by G. Allen Power, MD. 2011
- Many materials regarding dietary, bathing and other strategies on www.pioneer-network.net.

Activity Ideas & Products for Persons Who Have Dementia

- *Keeping Busy…A Handbook of Activities for Persons with Dementia* by James Dowling 1995.
- *Failure-Free Activities for the Alzheimer Patient: A Guidebook for Caregivers* by Carmel B. Sheridan. 1987
- *The Positive Interactions Program of Activities for People with Alzheimer's Disease* by Sylvia Nissenboim, Christine Vroman. 1998.
- *Creating Moments of Joy* by Jolene A. Brackey. 2017.
- www.sootheze.com: Heated and Weighted Animals and Throws
- www.memorable Pets.com: A large selection of very lifelike and soft animals
- S & S Worldwide Catalog at www.ssww.com : Has large puzzles, games and other appropriate activities for someone with dementia
- www.hippocampus-hq.com-Has many, different activities and games for individuals and for groups.

Music and Movement Resources

- *Alive Inside: A story of Music and Memory. 2014.* This video shows very clearly the power of music and rhythm with people who have dementia. Some portions are available to view for free on You Tube.
- *www.*sitandbefit.org. Lots of videos and materials to help keep people with dementia moving. Also has chair exercises.

Elements of Positive Approach & Hand Under Hand Assistance

1. Come from the FRONT—ALWAYS!! Get into visual range.
2. Get LOW-Match eye level. Go SLOW
3. ANNOUNCE/Introduce yourself (where is your name tag?)
4. Pause at the EDGE of Public Space (About 6 feet), move slowly into personal space(about 2-3 feet).
5. Offer Your HAND in a handshake. Greet and smile.
6. Use the person's NAME (which name?)
7. Wait for a RESPONSE-Get permission to move closer.
8. Get to the SIDE-The *person's* dominant side.
9. Be friendly—give message, simple, short, sweet.
10. Use Hand UNDER Hand Assistance. Your hand pivots with the thumb and goes under the person's hand.

Your Other Hand:

- ☐ Place on the person's *shoulder* to provide stimulation & a closed neurological loop for activities.
- ☐ Hold the person's *other hand* for guidance
- ☐ Place on the person's *lower back* for support
- ☐ *Use to pick up items* to assist with the activity itself

Use This Stance To....

- ☐ Gauge a person's response to touch.
- ☐ Establish safe physical boundaries.
- ☐ Guide hand and arm movement.

Positive Approach and Hand Under Hand Assistance are approaches developed by Teepa Snow OTR/L and used with permission by Positive Approach to Change(PAC) 2018. For more information and other training materials go to www.teepasnow.com

My companion has dementia, and may need extra help and patience. Thank you for your support and understanding.

alzheimer's association®

alz.org | 800.272.3900

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Bathing

As Alzheimer's progresses, people with the disease eventually need help with bathing. This need commonly begins in the middle (sometimes referred to as moderate in a medical context) stage and continues into the late (severe) stage. Bathing can be a challenge because people with Alzheimer's may be uncomfortable receiving assistance with such an intimate activity. They may also have depth perception problems that make it scary to step into water. They may not perceive a need to bathe or may find it a cold, uncomfortable experience.

If people regard bathing as scary, embarrassing, unpleasant or uncomfortable, they may communicate their discomfort by verbally and/or physically resisting attempts to bathe them. In some cases this can escalate and become be unsafe and upsetting for all who are involved. There are ways to make bathing easier and more comfortable – however, each situation is unique, and finding what works is often the result of trial and error. The following tips may help:

Know the person's abilities.
Encourage the person to do as much as possible, but be ready to assist when needed. Understanding the person's abilities will help you know where to focus your help. Assess his or her ability to:

- Find the bathroom.
- See clearly.
- Maintain balance without fear of falling.
- Reach and stretch arms.
- Remember the steps in the bathing process, follow cues or examples.
- Know how to use different products (soap, shampoo, washcloth, etc.).
- Sense water temperature.

Prepare the bathroom in advance.

- Gather bathing supplies such as towels, washcloths, shampoo and soap before you tell the person that it's time to bathe.
- Make sure the room is warm.
- Place a shower stool inside the tub or shower. Pad the seat and other cold or uncomfortable surfaces with towels.
- Use large beach towels or bath blankets that completely wrap around the person for privacy and warmth.
- Have a washcloth ready to cover the person's eyes to prevent stinging from water or shampoo.
- Make sure that soap and shampoo are within reach.
- Fill the tub and then assess the person's reaction to getting into the water.
- Use only two or three inches of water.
- Try using a hand-held showerhead, but make sure the spray isn't too harsh.

- Monitor the water temperature. The person may not sense when the water is dangerously hot or may resist bathing if the water is too cool.

Focus on the person, not the task.

- Give the person choices. For example, ask if he or she would like to bathe now or in 15 minutes, or take a bath or a shower. Try saying "Let's wash up," instead of "Let's take a bath."
- Be sure the person has a role in the bathing process. For example, have the person hold a washcloth, sponge or shampoo bottle.
- Be aware that the person may perceive bathing to be threatening. If the person is resistant, distract him or her and try again later.
- Praise the person for his or her efforts and cooperation.
- Always protect the person's dignity, privacy and comfort. Consider covering the person with a bath towel while undressing to decrease feelings of vulnerability.
- Try having a familiar person of the same sex help with bathing if that is more comfortable for the person with dementia.
- Try different approaches to coax the person into the tub or shower. For instance, allow the person to get into the tub or shower with a towel on to reduce embarrassment or to help the person feel warmer.
- Have activities ready in case the person becomes agitated. For example, play soothing music or sing together.

Adapt the bathing process.

- Try bathing at the same time of day the person is used to. If the person is usually a morning bather, a bath in the evening may be confusing.
- Use simple phrases to coach the person through each step of the process, such as, "Put your feet in the tub." "Sit down." "Here's the soap." "Wash your arm."
- Use other cues to remind the person what to do, such as the "watch-me" technique where you demonstrate the action, putting your hand over the person's hand, gently guiding the washing actions.
- Use a tub bench or bath chair that can adjust to different heights so the person can sit while showering, if easier.
- Washing the person's hair may be the most difficult task. Use a washcloth to reduce the amount of water on the person's face.
- Be sure the person's genital areas are washed, especially if incontinence is a problem, as well as between folds of skin and under the breasts.

Simplify the process.

- Sew pockets into washcloths to hold soap.
- Use an all-purpose gel to wash both hair and body.
- Use a nylon net sponge, which requires less work to make suds.

Consider bathing alternatives.

- Be open to adjusting your bathing standards. Your preferences regarding bathing may not match the needs or realities of the person for whom you are caring.
- Wash one part of the body each day of the week.
- Shampoo hair at another time or on a different day.
- Give the person a sponge bath with a washcloth between showers or baths.
- Use a non-rinse soap product with warm, wet towels to clean the person. Research shows that regular, thorough use of this type of product, which can be purchased at a pharmacy or drug store, is equally effective.
- Have a trained caregiver or nursing assistant come to the house to bathe the person.

Remember after-bath care.

- Check for rashes and sores, especially if the person is incontinent or unable to move around.
- Seat the person while drying and putting on fresh clothes.
- Make sure the person is completely dry. Pat the person dry instead of rubbing.
- Use cotton swabs to dry between the toes.
- Gently apply lotion to keep skin soft.
- Use cornstarch or talcum powder under the breasts and in the creases and folds of skin. If the person will not use deodorant, use baking soda.

Make the bathroom safe.

- Provide supervision as needed in the bathroom, especially if the person is unsteady.
- Lower the thermostat on your hot water heater to prevent scalding injuries.
- Always check the water temperature, even if the person draws his or her own bath.
- Place a nonskid mat in the tub or shower.
- Install grab bars and use a seat in the tub or shower.
- Make sure there are no puddles on the bathroom floor. Consider installing carpet.

TS-0015 | Updated March 2017

Dressing

Physical appearance contributes to a person's sense of self-esteem. For a person with middle- or late-stage (sometimes referred to as moderate or severe, respectively, in a medical context) Alzheimer's disease, choosing and putting on clothes can be frustrating. He or she may not remember how to dress or may be overwhelmed with the choices or the task itself.

There are many reasons why a person with middle- or late-stage Alzheimer's might have difficulty dressing. Consider the following when trying to understand the cause(s):

Physical.
- Does the person have problems with balance or lack the motor skills needed to fasten buttons or close zippers?
- Does the person remember how to put clothes on and in what sequence?
- Does he or she recognize her clothes?
- Is he or she aware of the time of day or season of the year?
- Is the person in pain due to arthritis or some other issue affecting movement?

Environmental.
- Is the person troubled by lack of privacy, a cold room, poor lighting or loud noises?

Other concerns.
- Is the person being rushed to get dressed quickly?
- Is the person receiving clear step-by-step instructions on how to dress or does the task seem too complicated?
- Is the person embarrassed by dressing in front of you or others?

Encourage the person to do as much as possible, but be ready to help when needed. The following tips may be helpful in providing dressing assistance to the person with dementia:

Simplify choices.
- Lay out clothes for the person.
- When possible, give the person an opportunity to select favorite outfits or colors. Try offering only two choices of a clothing item (e.g., two pants or two skirts).
- Keep closets free of excess clothing. A person may find many clothing choices overwhelming.

Choose comfortable and simple clothing.
- Select comfortable clothing that's easy to put on and remove.
- Cardigans, shirts and blouses that button in front are sometimes easier to work than pullover tops.

- Substitute Velcro for buttons, snaps and zippers, which may be too difficult to handle.
- To avoid tripping and falling, make sure that clothing length is appropriate.
- Make sure the person wears comfortable, non-slip shoes.
- If the person is confined to a wheelchair, adapt regular clothes to protect his or her privacy and allow for greater comfort.
- Make sure that clothing is loose fitting, especially at the waist and hips, and choose fabrics that are soft and stretchable.

Organize the dressing process.

- Lay out clothes in the order each item should be put on.
- Hand the person one item of clothing at a time while giving short, simple instructions such as "Put on your shirt," rather than "Get dressed."
- Don't rush the person – haste can cause anxiety.

Be flexible.

- If the person wants to wear the same outfit repeatedly, consider purchasing a duplicate or having similar options available.
- It's alright if the person wants to wear several layers of clothing, just make sure he or she doesn't get overheated.
- When outdoors, be sure the person is dressed properly for the weather.
- It's OK if clothing is mismatched – try to focus on the fact that he or she was able to get dressed.

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Eating

Proper nutrition is important to keep the body strong and healthy. However, regular nutritious meals may become increasingly challenging for people with middle- or late-stage (sometimes referred to as moderate or severe, respectively, in a medical context) Alzheimer's. They may become overwhelmed with too many food choices, forget to eat or think they've already eaten. If a person is having difficulty eating, consider the following questions to help assess the situation:

- **Physical difficulties.**
  Is the problem physical? Mouth sores, poor-fitting dentures, gum disease or dry mouth may make eating difficult.
- **Other diseases or conditions.**
  Does the person have other chronic conditions? Intestinal or cardiac problems or diabetes might lead to loss of appetite. Conditions such as indigestion, constipation or depression can also decrease appetite.
- **Agitation and distraction.**
  Is the person agitated or distracted? If so, he or she may not sit for an entire meal. Think about how you can reduce distractions in the eating area.
- **Eating style.**
  Does the person have a preferred eating style? Those unaccustomed to sitting at the table for three full meals may prefer to have several smaller meals or snacks.
- **Environment.**
  Are there unpleasant odors or harsh noises in the room that might be distracting?
- **Food quality.**
  Is the food appealing in appearance, smell and taste?
- **Food preferences.**
  Are you considering the person's food likes and dislikes? Long-standing personal preferences should be kept in mind when preparing food.

Each person is unique, but the following tips may be helpful as you assist with mealtimes and eating during the middle and late stages of the disease:

Nutrition tips.
The basic health tips below may benefit both the person with dementia and the caregiver.

- Provide a balanced diet with a variety of foods. Offer vegetables, fruits, whole grains, low-fat dairy products and lean protein foods.
- Limit foods with high saturated fat and cholesterol. Some fat is essential for health — but not all fats are equal. Go light on fats that are bad for heart health, such as butter, solid shortening, lard and fatty cuts of meats.
- Cut down on refined sugars. Often found in processed foods, refined sugars contain calories but lack vitamins, minerals and fiber. You can tame a sweet

tooth with healthier options like fruit or juice-sweetened baked goods. But note that in the later stages of Alzheimer's, if appetite loss is a problem, adding sugar to foods may encourage eating.

- Limit foods with high sodium and use less salt. Most people in the United States consume too much sodium, which affects blood pressure. As an alternative, use spices or herbs to season food.

As the disease progresses, loss of appetite and weight loss may become concerns. In such cases, the doctor may suggest supplements between meals to add calories.

Staying hydrated may also be a problem. Encourage fluid intake by offering small cups of water or other liquids throughout the day or foods with high water content, such as fruit, soups, milkshakes and smoothies.

Make mealtimes calm and comfortable.

Tips for the middle stage:

- Serve meals in quiet surroundings, away from the television and other distractions.
- Keep the table setting simple and avoid patterned plates, tablecloths and placemats that might confuse the person. Using color to contrast plates against a tablecloth or placemat can make it easier for the person to distinguish the food from the plate or table. Consider using a plastic tablecloth, napkins or aprons to make cleanup easier.
- Provide only the utensils needed for the meal to avoid confusion.
- Serve one or two foods at a time. For example, serve mashed potatoes followed by cooked meat.
- Use simple, easy-to-understand instructions. For example, “Pick up your fork. Put some food on it. Raise it to your mouth.”
- Check the food temperature before consumption. The person might not be able to tell if a food or beverage is too hot.
- Be patient. Don’t criticize the person’s eating habits or urge him or her to eat faster.
- Speak slowly and clearly. Be consistent and repeat instructions using the same words.
- If the person doesn’t want to eat, take a break, involve him or her in another activity and return to eating later.
- Use memory aids to remind the person about meal times. Consider using a clock with large numbers, an easy-to-read appointment calendar with large letters and numbers or a chalk or bulletin board for recording the daily schedule.

Tips for the late stage:

- Allow plenty of time to eat. Keep in mind that it can take an hour or more for the person to finish.
- For as long as possible, give the person the opportunity to eat with others.

Encourage independence.

Tips for the middle stage:

- Serve finger foods or a meal in the form of a sandwich in order to make it easier for the person to serve him or herself.
- Serve food in large bowls instead of plates, or use plates with rims or protective edges.
- When needed, use spoons with large handles instead of forks, or use weighted utensils.
- Set bowls and plates on a non-skid surface such as a cloth or towel.
- Use cups and mugs with lids to prevent spilling. Fill glasses half full and use bendable straws.

Tips for the late stage:

- Gently place the person's hand on or near an eating utensil.
- Show the person how to eat by demonstrating eating behavior. Or try hand-over-hand feeding by putting a utensil in the person's hand, placing your hand around theirs and lifting both of your hands to the person's mouth for a bite.

Minimize eating and nutrition problems.

Tips for the middle to late stages:

- Avoid foods such as nuts, popcorn and raw carrots, which may be difficult to chew and swallow.
- When needed, grind foods or cut them into bite-size pieces.
- Serve soft foods such as applesauce, cottage cheese and scrambled eggs.
- Serve thicker liquids such as shakes, nectars and thick juices, or serve a liquid along with the food.
- Encourage the person to sit up straight with his or her head slightly forward, to avoid choking. If the person's head tilts backward, move it to a forward position.
- Use vitamin supplements only when recommended by a physician. Monitor usage.
- If the person has a decreased appetite, try preparing some of his or her favorite foods. You may also consider increasing the person's physical activity or plan for several small meals rather than three large meals.
- After the meal is over, check the person's mouth to make sure the food is swallowed.
- Learn the Heimlich maneuver and be alert for signs of choking.

- The person may not remember when or if he or she ate. If the individual continues to ask about eating breakfast, you might consider breaking up the meal — juice, followed by toast, followed by cereal.
- Help the person maintain good oral hygiene. If it's difficult to use a toothbrush, try oral swabs. Make regular visits to the person's dentist.

TS-0024 | Updated March 2017

alzheimer's association®

Home Safety Checklist

Individuals living with Alzheimer's disease and other dementias are at increased risk for injury or harm in certain areas of the home. As the disease progresses, they may become unaware of the dangers that exist. Consider taking the following precautions to create a safe environment which can prevent dangerous situations from occurring and help maximize independence for as long as possible.

General Home Safety Tips

- ☐ Store potentially hazardous items, such as medication, alcohol, matches, sharp objects or small appliances and tools, in a securely locked cabinet.
- ☐ Keep all cleaning products, such as liquid laundry pacs and bleach, out of sight or secured to avoid possible ingestion of harmful chemicals.
- ☐ Keep the number for the local poison control center posted by the telephone in case of emergency.
- ☐ Make sure carbon monoxide, smoke detectors and fire extinguishers are available and inspected regularly. Replace batteries twice a year during daylight saving time.
- ☐ Remove tripping hazards, such as throw rugs, extension cords and excessive clutter.
- ☐ Keep walkways and rooms well lit.
- ☐ Secure large furniture, such as book shelves, cabinets or large TVs, to prevent tipping.
- ☐ Ensure chairs have arm rests to provide support when going from a sitting to standing position.
- ☐ Apply stickers to glass doors at eye-level to ensure doors are visible.
- ☐ Install a latch or deadbolt on all doors that is either above or below eye-level.
- ☐ Remove locks on interior doors to prevent the person with dementia from locking themselves in.
- ☐ Consider removing firearms from the home or storing them in a locked cabinet.
- ☐ Enroll in MedicAlert® + Alzheimer's Association Safe Return®, a 24-hour nationwide emergency response service for individuals with Alzheimer's or other dementias.

Home Safety Checklist made possible through a collaboration with Procter & Gamble.

Kitchen

☐ Use appliances that have an auto shut-off feature.
☐ Prevent unsafe stove usage by applying stove knob covers, removing knobs or turning off the gas when the stove is not in use.
☐ Disconnect the garbage disposal.
☐ Mark food with purchase date ; regularly check for and throw away expired items.
☐ Discard toxic plants and decorative fruits that may be mistaken for real food.
☐ Remove vitamins, prescription drugs, sugar substitutes and seasonings from the kitchen table and counters.

Laundry Room

☐ Clean out lint screens and dryer ducts regularly to prevent fires.
☐ Consider installing safety locks on washing machines and dryers to prevent inappropriate items being put in or taken out too early.
☐ Install locks on laundry chutes to avoid temptation to climb into or drop inappropriate items down the chute.
☐ Keep all cleaning products, such as liquid laundry pacs and bleach, out of sight or secured to avoid possible ingestion of harmful chemicals.

Bathroom

☐ Install grab bars for the shower, tub and toilet to provide additional support.
☐ Set the water temperature at 120 degrees Fahrenheit or less to prevent scalding.
☐ Apply textured stickers to slippery surfaces to prevent falls.

Bedroom

☐ Closely monitor the use of an electric blanket, heater or heating pad to prevent burns or other injuries.
☐ Provide seating near the bed to help with dressing.
☐ Ensure closet shelves are at an accessible height so that items are easy to reach, which may prevent the person from climbing shelves or objects falling from overhead.

Garage and Basement

☐ Limit access to large equipment, such as lawn mowers, weed trimmers or snow blowers.
☐ Keep poisonous chemicals, such as gasoline or paint thinner, out of reach.
☐ Lock and properly store ladders when not in use to prevent a tripping or climbing hazard.
☐ Remove access to car keys if the individual with dementia is no longer driving.
☐ Install a motion sensor on the garage door.
☐ Mark stairs with bright tape and ensure railings are sturdy and secure to prevent tripping or falls.

Home Safety Checklist made possible through a collaboration with Procter & Gamble.

Incontinence

As Alzheimer's disease progresses, it is common for incontinence of the bladder and bowels to occur, particularly in the middle and late stages. Common causes include inability to recognize natural urges, forgetting where the bathroom is or side effects from medicine.

Causes of incontinence

If a person with Alzheimer's has recently started to lose control of his or her bladder and bowels, the first and most important step is to determine the possible causes. Consider the following:

Medical conditions

Consult a physician to determine if the cause is medical and treatable.

- Urinary tract infection, constipation or a prostate problem.
- Diabetes, stroke or a muscular disorder such as Parkinson's disease.
- Physical disabilities that prevent reaching the bathroom in time.

Medications and diuretics

- Sleeping pills and anxiety-reducing drugs may relax the bladder muscles.
- Drinks like cola, coffee and tea can act as diuretics, which increase urination.

Environment and clothing

- Make sure it's easy to locate and identify the bathroom.
- Create a path to the bathroom that is well lit and obstacle-free.
- Wear clothes that are easy to put on and remove.

Dehydration

- Don't limit fluids. This could cause dehydration, which could lead to a urinary tract infection and increased incontinence.

Tips for approaching incontinence

Although incontinence typically occurs in the middle or late stages of Alzheimer's, every situation is unique. The following tips can help caregivers of people with Alzheimer's who are experiencing incontinence.

Understand

- Bladder and bowel accidents can be embarrassing. Find ways to preserve dignity. For example say, "Anyone can have an accident" instead of saying, "You wet yourself."
- Be matter-of-fact; don't scold or make the person feel guilty.
- Respect the need for privacy as much as possible.

Communicate

- Encourage the person to tell you when he or she needs to use the toilet.
- Watch for nonverbal cues, such as restlessness, making unusual sounds or faces, pacing, sudden silence or hiding in corners. These cues may indicate the need to use the toilet. Use adult words rather than baby talk to refer to using the toilet.

- Learn the person's trigger words or phrases for needing to use the toilet. The person may use words that have nothing to do with toileting (e.g., "I can't find the light"), but to that person, it means going to the bathroom. Communication challenges often increase in the late stage of the disease.
- Some people do well when they are reminded to go to the bathroom on a regular schedule, perhaps every two hours.

Make it easy to find the bathroom and use the toilet

- Keep the bathroom door open so the toilet is visible.
- Put a picture of a toilet on the bathroom door.
- Paint the bathroom door with a color in contrast to the wall.
- Make the toilet safe and easy to use. For example, raise the toilet seat, install grab bars on both sides of the toilet and use nightlights to illuminate the bedroom and bathroom.
- Consider a portable commode or urinal for the bedroom.
- Remove plants, wastebaskets and other objects if mistaken for a toilet.

Plan ahead

- Observe and recognize the person's routine toilet schedule.
- Provide a reminder to use the bathroom just before his or her usual time.
- Try setting a regular schedule for toilet use. For example, help the person to the bathroom first thing in the morning, every two hours during the day, immediately after meals and just before bedtime.
- Identify when accidents occur, then plan for them. If they happen every two hours, get the person to the bathroom before that time.

Follow up

- Check the toilet to see if the person has used it.
- Help the person wipe and then flush the toilet as needed.
- Regularly wash sensitive skin areas.

Monitor fluids

- Encourage overall fluid intake, but limit the fluid intake before bedtime.
- Cut down on drinks that stimulate urination, like cola, coffee or tea.

Adjust and innovate

- Choose clothing that is easy to remove and to clean.
- Consider using padded undergarments or adult briefs. Even if a person doesn't need them ordinarily, they can be helpful when you're in a place where getting to a toilet might be difficult.
- Give the person plenty of time to empty his or her bladder and bowels.
- If the person has difficulty urinating, run water in the sink or give the person a drink for stimulation.
- Use waterproof mattress covers, incontinence pads or both on the person's bed to help keep fluid from soaking into the mattress.

Medication and safety

For individuals living with Alzheimer's and other dementias, medication safety involves an understanding of the purpose and appropriate use of each medication, as well as a system of organization and safety measures to avoid risk as the disease progresses. A plan to safely manage prescription and over-the-counter medications is critical to avoid medication-related problems.

Get the facts.

Currently, there is no medication to prevent, cure or slow Alzheimer's disease, but multiple medications may be prescribed for symptoms of Alzheimer's or other conditions commonly associated with the diagnosis, such as depression, anxiety or sleeplessness. When a medication is prescribed or a supplement is recommended, it is important to get the facts about each treatment. This can help ensure you understand all the available options, benefits and risks.

Consider asking your doctor or pharmacist the following questions to help determine the best treatment plan:

- **Purpose of medication.**
  Which symptoms will the medication address and are there any warning signs that would indicate the medication is not working as intended?
- **Side effects.**
  What are the possible side effects of each medication? Which drug interactions may occur with current medications? Be sure that all members of the care team are aware of the medications prescribed.
- **Appropriate use.**
  Medications should only be taken as directed. Ask about proper dosage amounts and delivery methods to maximize the effectiveness of the treatments and prevent accidental overdose. Some medications may be available in liquid form to aid ingestion. Always consult with the prescribing physician or pharmacist before crushing or breaking pills.

Manage medications.

In the early stage of Alzheimer's disease, individuals are able to understand the use of medications and may use reminders such as pill organizers, sticky notes or calendars to independently manage medications. As the disease progresses, more assistance will be required to oversee and administer medications. If multiple medications have been prescribed for other serious health conditions, an organization system is essential to avoid missed or incorrect dosage that could lead to serious consequences.

Consider these tips when managing medications:

- **Stay organized.**
  Use a pill box or organizer to sort medication by the day and time in which they should be taken. A friend, family member or pharmacist may be able to

assist with filling the organizer. If this support is not available, consider hiring a home health agency to assist with medication management.

- **Maintain medication records.**
  Keep a written record of all current medications, including the name, dosage and starting date. Consider signing up for MedicAlert® + Alzheimer's Association Safe Return®, a service that provides an online personal health record of your health conditions and current medications. This record is invaluable in the event of a medical emergency.
- **Develop a routine.**
  Ask the pharmacist how medications should be taken — at a certain time of the day or with or without food. Then create a daily routine, such as taking medications with meals or before bed.

Avoid risk.
Consult with your doctor or pharmacist if you have questions or concerns about managing medications. Many problems can be prevented by considering the following tips:

- Do not take old medications; check expiration dates and follow instructions for safe disposal.
- Never share prescription medications with others.
- As the disease progresses, keep cabinets and medication storage secure to prevent accidental overdose.
- Keep the number of your local poison control center handy. If you suspect a medication overdose, call poison control or 911 before taking action.

TS-0013 | Updated April 2017

Wandering behavior:
Preparing for and preventing it

Alzheimer's disease causes millions of Americans to lose their ability to recognize familiar places and faces. Up to 60 percent of those with dementia will wander. And people can wander or become confused about their location at any stage of the disease, even in the early stage. Although common, wandering can be dangerous — even life-threatening. The following information can help caregivers and family members prepare for and prevent wandering behavior:

Signs of wandering behavior

- Returning from a regular walk or drive later than usual.
- Forgetting how to get to familiar places.
- Trying to fulfill former obligations, such as going to work.
- Trying to "go home" even when at home.
- Acting restless, pacing or making repetitive movements.
- Having difficulty locating familiar places like the bathroom, bedroom or dining room.
- Asking the whereabouts of current or past friends and family.
- Acting as if doing a hobby or chore, but nothing gets done.
- Appearing lost in a new or changed environment.

Tips to reduce wandering

The following strategies may help lower the chances of wandering.

- Carry out daily activities. Having a routine can provide structure.
- Identify the most likely times of day that wandering may occur. At those times, plan activities such as exercise, which can help reduce anxiety, agitation and restlessness.
- Offer reassurance if the person feels lost, abandoned or disoriented. Use communication focused on validation and refrain from correcting the person. For example, "We're staying here tonight. We're safe and I'll be with you."
- Ensure all basic needs are met (e.g., hunger, thirst, toileting).
- Avoid busy places that are confusing and can cause disorientation (e.g., shopping malls, grocery stores).
- If night wandering is a problem, make sure the person has restricted fluids two hours before bedtime and has gone to the bathroom just before bed.

Prepare your home

Based on the individual needs and behaviors of the person with dementia, the following suggestions may be helpful in preventing wandering.

- Use night lights throughout the home.
- Place locks out of the line of sight. Install slide bolts at the top or bottom of doors.
- Cover door knobs with cloth the same color as the door. Use childproof knobs.
- Camouflage doors by painting them the same color as the walls. Cover them with removable curtains or screens.
- Use black tape or paint to create a two-foot black threshold in front of the door.
- Place warning bells above doors.

- Use monitoring devices that signal when a door is opened.
- Place a pressure-sensitive mat at the door or person's bedside to alert you to movement.
- Put hedges or a fence around the patio, yard or other outside common areas.
- Use safety gates or brightly colored netting to bar access to stairs or the outdoors.
- Consider providing an easily accessible recliner or geriatric chair for the individual to sit and rest.
- Monitor noise levels to help reduce excessive stimulation.
- Create indoor and outdoor common areas that can be safely explored.
- Label all doors with signs or symbols to explain the purpose of each room.
- Secure trigger items that a person would not go out with out, such as a coat, hat, pocketbook, keys and wallet
- Avoid leaving a person with dementia alone in a car.

Planning ahead

- Enroll the person in MedicAlert® + Alzheimer's Association Safe Return® and make sure MedicAlert + Safe Return always has a recent photo and updated medical information for the person.
- Ask neighbors, friends and family to call if they see the person alone or dressed inappropriately.
- Keep a recent, close-up photo on hand to give to police, should the need arise.
- Know your neighborhood. Pinpoint dangerous areas near the home, such as bodies of water, open stairwells, dense foliage, tunnels, bus stops and roads with heavy traffic.
- Is the individual right- or left-handed? Wandering generally follows the direction of the dominant hand.
- Keep a list of places where the person may wander to, such as past jobs, former homes or a church or restaurant.

Resources

- MedicAlert® + Alzheimer's Association Safe Return® (877.572.8566 or alz.org/safety).

TS-0032 | Updated February 2014

Down syndrome and Alzheimer's disease

A topic in the Alzheimer's Association® series on understanding dementia.

About dementia
Dementia is a condition in which a person has significant difficulty with daily functioning because of problems with thinking and memory. Dementia is not a single disease; it's an overall term — like heart disease — that covers a wide range of specific medical conditions, including Alzheimer's disease. Disorders grouped under the general term "dementia" are caused by abnormal brain changes. These changes trigger a decline in thinking skills, also known as cognitive abilities, severe enough to impair daily life and independent function. They also affect behavior, feelings and relationships.

Brain changes that cause dementia may be temporary, but they are most often permanent and worsen over time, leading to increasing disability and a shortened life span. Survival can vary widely, depending on such factors as the cause of the dementia, age at diagnosis and coexisting health conditions.

Down syndrome and Alzheimer's disease
Down syndrome — also known as trisomy 21 — is a condition in which a person is born with extra genetic material from chromosome 21, one of the 23 human chromosomes. All human chromosomes usually occur in pairs, with one copy inherited from a person's mother and one from the father. Most people with Down syndrome have a full extra copy of chromosome 21, so they have three copies instead of the usual two. Scientists think the extra copy results from a random error in the specialized cell division that produces eggs and sperm.

Human chromosomes carry about 30,000 genes coding a person's entire biological blueprint. Genes tell the body how to build proteins — the key molecules underlying all the body's structures and functions. Researchers have so far identified more than 400 genes on chromosome 21, and they expect to find more.

In ways that scientists don't yet understand, the extra copies of genes present in Down syndrome cause developmental problems and health issues even though all three copies of the genes usually carry "normal" protein codes. Down syndrome nearly always affects learning, language and memory, but its impact varies widely from person to person. Other common health issues include heart defects present at birth, conditions affecting bones and muscles, and problems with vision and hearing. A core goal of Down syndrome research is to understand how the extra copy of chromosome 21 and its genes cause problems just by existing.

Advances in function, well-being and life span for people with Down syndrome have revealed an additional health risk: As they age, individuals affected by Down syndrome have a greatly increased risk of developing a type of dementia that's either the same as or very similar to Alzheimer's disease.

Autopsy studies show that by age 40, the brains of almost all individuals with Down syndrome have significant levels of beta-amyloid plaques and tau tangles, which are abnormal protein deposits considered hallmarks of Alzheimer's disease. But despite the near-universal presence of these brain changes, not everyone with Down syndrome develops Alzheimer's symptoms. One of the many questions researchers hope to answer about Down syndrome is why some people develop dementia symptoms and others don't. Researchers are working to answer a similar key question about those who don't have Down syndrome: Why do some people with levels of brain changes characteristic of Alzheimer's never show symptoms of the disease?

Prevalence

About 400,000 Americans have Down syndrome. As with all adults, advancing age increases the chances a person with Down syndrome will develop Alzheimer's. Studies suggest that more than 75 percent of those with Down syndrome age 65 and older have Alzheimer's disease, nearly six times the percentage of people in this age group who do not have Down syndrome. Because people with Down syndrome live, on average, 55 to 60 years, they are more likely to develop younger-onset Alzheimer's (occurring before age 65) than older-onset Alzheimer's (occurring at age 65 or older).

Causes and risk factors

Scientists think that the increased risk of dementia — like other health issues associated with Down syndrome — results from the extra genes present. One of the chromosome 21 genes of greatest interest in the Down syndrome/Alzheimer's connection codes amyloid precursor protein (APP). Scientists don't yet know APP's function, but they've learned that day-to-day brain activity involves continuous "processing" of APP into shorter pieces. One of the brain's APP processing pathways produces beta-amyloid, a fragment that's the chief component of plaques and a prime suspect in Alzheimer's-related brain changes. Having an extra copy of the APP gene may increase production of beta-amyloid, triggering the chain of biological events leading to Alzheimer's.

The APP gene is further implicated in Alzheimer's through its connection to rare inherited forms of Alzheimer's disease. Certain small variations in the APP chemical code were the first genetic changes scientists identified that guarantee people will develop Alzheimer's if they inherit such a change from either parent. Like other genetic variations that ensure a person will develop Alzheimer's, these APP variations are extremely rare. Few, if any, people with Down syndrome have them.

The fact that APP is strongly implicated in Alzheimer's through two different mechanisms — one involving a whole extra copy of the normal gene and the other involving specific minor changes in the gene's chemical code — makes the intersection of Down syndrome and Alzheimer's a strong focus of research.

Symptoms

In people with Down syndrome, changes in overall function, personality and behavior may be more common early signs of Alzheimer's than memory loss and forgetfulness. Early symptoms may include:

- Reduced interest in being sociable, conversing or expressing thoughts.
- Decreased enthusiasm for usual activities.
- Decline in ability to pay attention.
- Sadness, fearfulness or anxiety.
- Irritability, uncooperativeness or aggression.
- Restlessness or sleep disturbances.
- Seizures that begin in adulthood.
- Changes in coordination and walking.
- Increased noisiness or excitability.

Diagnosis

Most adults with Down syndrome will not self-report concerns about memory. Diagnosing dementia in a person with Down syndrome can be difficult, in part because of the challenges involved in assessing thinking-skill changes in those with intellectual disabilities. Yet, recognition of adult cognitive change is important for providing appropriate services and support for individuals with Down syndrome and their caregivers. Experts recommend the following principles as key to person-centered diagnosis in those with Down syndrome:

- Document baseline adult function by age 35. Ongoing evaluation of intellectual, behavioral and social function is important for everyone with Down syndrome. By age 35, each individual's medical record should ideally include detailed information on his or her adult abilities. The person with Down syndrome, family members and other reliable individuals are helpful sources for this information.
- Watch for changes in day-to-day function. Reduced enthusiasm for daily activities, loss of interest in social interactions and changes in personality and behavior are often early signs of an underlying decline in thinking skills.
- Consider professional assessment by a dementia expert. A variety of cognitive tests have been used to evaluate thinking changes in adults with Down syndrome. However, experts caution that cognitive tests should never be used as the only benchmark to diagnose dementia.
- Rule out other causes of symptoms. It's important to rule out other medical conditions commonly associated with Down syndrome as the cause of changes in thinking and function, including thyroid problems, depression, chronic ear and sinus infections, vision loss and sleep apnea.

Outcomes

Despite modern improvements in quality and length of life, Down syndrome remains a condition that shortens life span. People with Down syndrome experience earlier-than-usual onset of a variety of conditions linked to aging in addition to Alzheimer's disease. People with Down syndrome currently live an average of about 55 to 60 years, although some live into their seventies and, rarely, into their eighties.

Treatment

The U.S. Food and Drug Administration (FDA) has not approved any drugs specifically to treat dementia associated with Down syndrome. In the United Kingdom, cholinesterase inhibitors, a class of drugs approved in the United States and many other countries to treat Alzheimer's disease, are approved to treat dementia in people with Down syndrome. An analysis by the Cochrane Reviews, an extensive series of reports by international experts evaluating treatment effectiveness, found that there isn't enough evidence to reach a conclusive judgment about the benefit of cholinesterase inhibitors for people with Down syndrome.

An international randomized trial has shown no benefit for the Alzheimer's drug memantine in adults with Down syndrome. Experts urge more research and clinical studies to identify effective treatments for dementia in those with Down syndrome. Because there may be differences in the way people with Down syndrome process medications, experts encourage caution about using any drug that has not specifically been shown to be safe and effective in this group.

Research

In November 2015, the National Institutes of Health launched a $37 million initiative to identify biomarkers in the blood and brain that can help identify and track Alzheimer's in people with Down syndrome. The Alzheimer's Association, the Linda Crnic Institute for Down Syndrome and the nonprofit Global Down Syndrome Foundation convened scientific workshops addressing Alzheimer's and Down syndrome, and are funding efforts to develop a blood test able to detect who is at high risk for developing Alzheimer's.

You can find a complete list of Alzheimer's trials involving people with Down syndrome at https://www.nia.nih.gov/alzheimers/clinical-trials.

Additional resources

National Down Syndrome Society
NDSS.org

Global Down Syndrome Foundation
globaldownsyndrome.org

National Down Syndrome Congress
www.ndsccenter.org

National Association for Down Syndrome
NADS.org

TS-0090 | Updated May 2016

Know a resident's rights in a care facility and when to speak up

If you or someone you care for is living in a care facility, you should be aware of a resident's rights to quality care. By educating yourself, you can monitor the level of care at the facility and, should a problem arise, know when to speak up and take action. The following information will help you learn about the rights and how to document problems, communicate effectively and find outside resources if necessary.

A resident's rights

If a person cannot exercise his or her rights, someone else must act to protect them. A person in residential care has the right to:

- Get information.
- Participate in care.
- Make choices.
- Voice complaints.
- Be treated with dignity and respect in privacy and confidentiality.
- Have possessions stored securely.
- Leave one facility and transfer to another.

Communicating a grievance

Problems can come up even in the best residential care facilities. The best way to ensure quality care is to get involved and stay involved. Below are some helpful tips:

Ask about the facility's grievance procedure.
Every facility has grievance policies for investigating and resolving complaints. Make sure to understand these policies before a problem arises.

Define and document your concerns.

- Gather as much information as possible.
- Be precise. Write down the date, time, location and names of individuals involved.
- Ask yourself the following questions:
  - What results do you expect?
  - How can this concern best be resolved?
  - What steps will you take?
- Write down the actions you and the staff members have taken so far.

Tips for talking with the care team:

- Calmly state the problem.
- Be clear and accurate; focus on the concern at hand.
- Listen to the other person's explanation of the problem.

  - Avoid placing blame. Instead of saying "You're doing that wrong," try offering a suggestion. For example, "I think my mother would react better to bathing in the morning. That was her routine at home."
  - Work together to create an action plan. Write it down.
  - Visit and monitor care often.

Use facility resources to take action
Each facility offers many ways to address concerns, solve problems and make necessary changes. Explore the systems the facility already has in place, which may include a grievance procedure, care and service plan meetings, and resident and family councils.

Address concerns directly
First, try to resolve a problem with the people who are directly involved. Talk to a supervisor if necessary. Remember that staff members give vital care and deserve respect. Communicating effectively with them should help resolve your problem.

Go to the next level
If talking to the people involved fails to help, go to the next level of management. You may need to work your way up the chain of command. Bring documentation to illustrate your concerns and remember to be respectful when discussing the issue.

Using outside resources to take action

If you cannot resolve your problem within the facility, consider using the help of an outside agency.

- The Alzheimer's Association can identify local resources, and provide advice on how to recognize quality dementia care and communicate effectively with care providers.
- A long-term care ombudsman advocates for quality residential care, teaches consumers and providers, and helps resolve residents' complaints. To find the ombudsman for your area, call the Eldercare Locator at 800.677.1116 or visit their website at eldercare.gov.
- Elder law attorneys respond to concerns about residents' rights and quality care. They also help in elder abuse and financial abuse cases. Ask a prospective attorney whether he or she regularly handles these matters, as not all attorneys specialize in elder law. To get a listing of elder law attorneys in your area, visit the Alzheimer's Association Community Resource Finder at alz.org/CRF or call 800.272.3900.

Spotting and reporting elder abuse

Each state has a different definition of elder abuse, neglect or exploitation. Elder abuse can be physical, sexual, emotional or psychological. Abuse also includes abandonment, neglect, and financial or material exploitation. The category of abuse depends on where it occurred and who did it. Domestic elder abuse happens in the home of the elder or a caregiver where the offender is someone close to the elder, such as a spouse, sibling, child, friend or caregiver.

Institutional elder abuse happens in a residential facility where the offender is usually a paid caregiver, staff member or professional. Self-neglect happens when the person cannot provide for his or her own needs of food, clothing, shelter, personal hygiene, medication or safety.

The following resources offer more information on elder abuse. In the event of suspected abuse or neglect, you'll be connected to your state or local adult protective services division or to a long-term care ombudsman.

- **National Center on Elder Abuse**
  ncea.aoa.org
- **Eldercare Locator**
  eldercare.gov
  800.677.1116

TS-0006 | Updated June 2018

Working with staff in a nursing home or assisted living facility

The needs of a person living with Alzheimer's will change as the disease progresses. You can help care staff meet a resident's changing needs by remaining actively involved in the care plan. Your involvement begins even before the person moves into a long-term care facility.

Intake and admissions

Prior to residency in an assisted living facility or nursing home, an intake meeting is held so that the care team can begin to learn about the person's history, cultural beliefs, needs, likes and dislikes. It's important to share as much information as possible in this meeting to ensure the team is prepared to provide the best care.

Assessment

An initial assessment is conducted before admission and then repeated at admission and regularly afterward. As a caregiver or family member, you should be present to share information and help note any changes in the person's health.

In the assessment, the staff tries to understand as much as possible about the resident regarding:

- Cognitive health.
- Physical health.
- Physical functioning.
- Behavior.
- Sensory abilities, such as vision and hearing.
- Communication abilities.
- Decision-making skills.
- Personal background.
- Spiritual needs.
- Cultural and personal preferences.

Care or service planning

Nursing homes and assisted living facilities make detailed plans for the care of each resident. In a nursing home, this is called a care plan. In an assisted living facility, the document is known as a service plan.

The care plan or service plan is drawn up at a care conference, which is attended by professional staff members as well as the resident and family members.

Care conferences are held routinely, every few months. They may also be called on an as-needed basis. The agenda includes discussing a resident's health, medications and activities. The care conference is a good place to meet staff members, ask questions and raise concerns.

Participate in the care plan

People living with dementia and their family members have a right to be included in care conferences and should try to be present. Ask to be included via conference call if you don't live nearby or are unable to attend in person.

Before the meeting:

- Ask that the meeting be held when you can attend.
- Request a copy of the current care plan so you can review it before the meeting.
- List the questions, changes, concerns or goals you'd like to discuss.

At the meeting:

- Involve the resident as much as possible.
- Ask questions to make sure you understand everything.
- Take notes.
- Be sure you agree with the care plan.
- Ask for a copy of the care plan.

Follow up:

- Stay involved in care. As the disease progresses, the person's needs will change.
- Log any reactions to the care plan, medication or treatment.
- Communicate regularly with the staff about the care plan.
- If the plan isn't working, ask for another care conference.

Resident council

A resident council is a group of residents who discuss concerns and arrange for activities. In nursing homes, staff members usually help lead resident councils. Assisted living facilities may offer other ways for residents to meet and discuss care. Inquire to see if there is an opportunity like this in the facility you are using.

Family council

A family council is a group of family members and/or friends of residents who meet to discuss the nursing home. Staff members may or may not be involved. An assisted living facility may have a family council or offer other means for families to discuss the facility's care. Ask to see if your facility offers this; it can be another way to stay involved with care.

TS-0014 | Updated July 2018

Notes:

Ohio Alzheimer's Association Programs and Resources

Tricia Bingham, MA, LSW
The Alzheimer's Association, Central Ohio Chapter

What’s next?
The Alzheimer’s Association is here to help

Tricia Bingham, MA, LSW

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Vision

A world without Alzheimer’s disease®.

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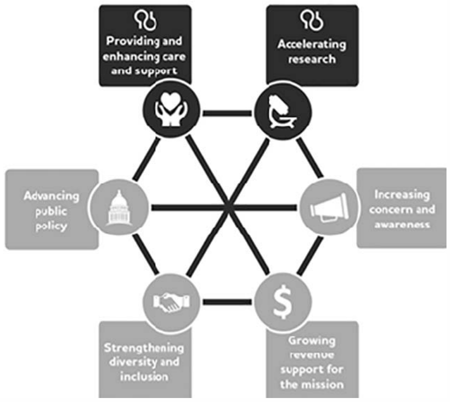
Six areas of focus



Providing and enhancing care and support

Accelerating research

Increasing concern and awareness

Growing revenue support for the mission

Strengthening diversity and inclusion

Advancing public policy

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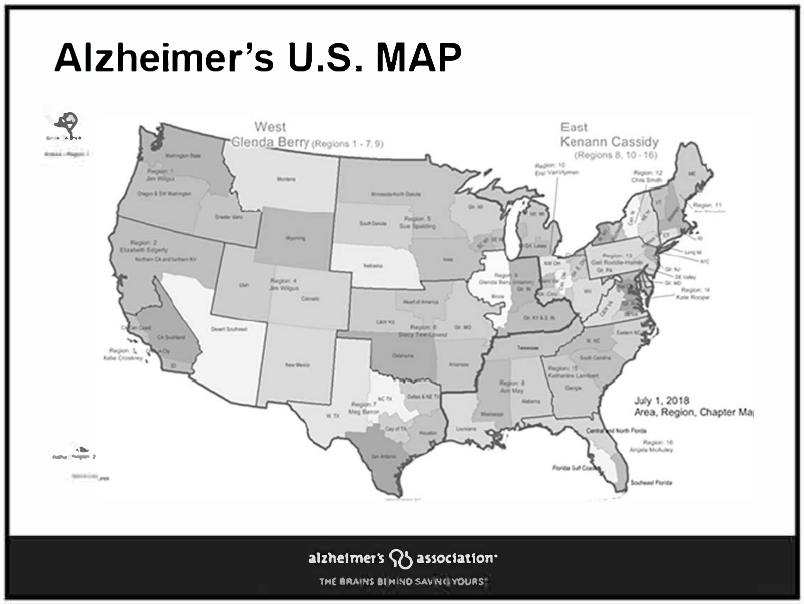

Alzheimer's U.S. MAP

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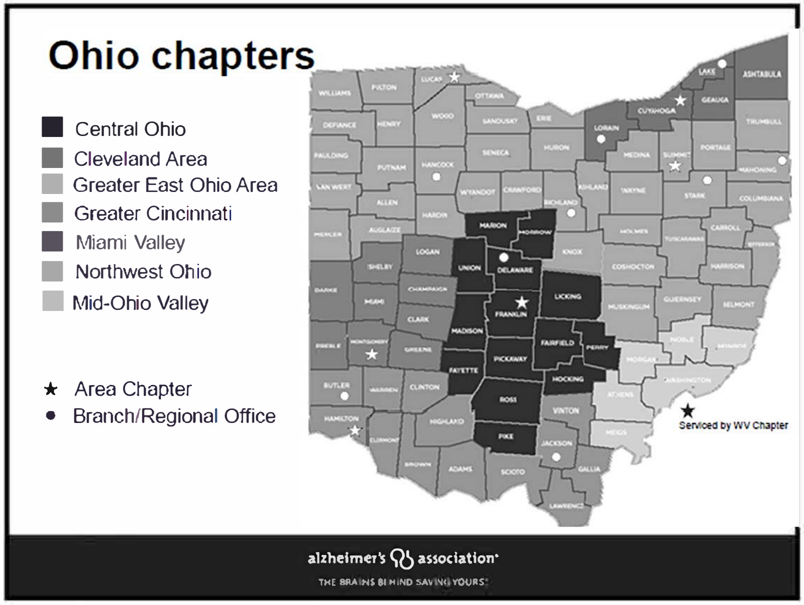

Ohio chapters

- ■ Central Ohio
- ■ Cleveland Area
- ■ Greater East Ohio Area
- ■ Greater Cincinnati
- ■ Miami Valley
- ■ Northwest Ohio
- ■ Mid-Ohio Valley

★ Area Chapter
● Branch/Regional Office

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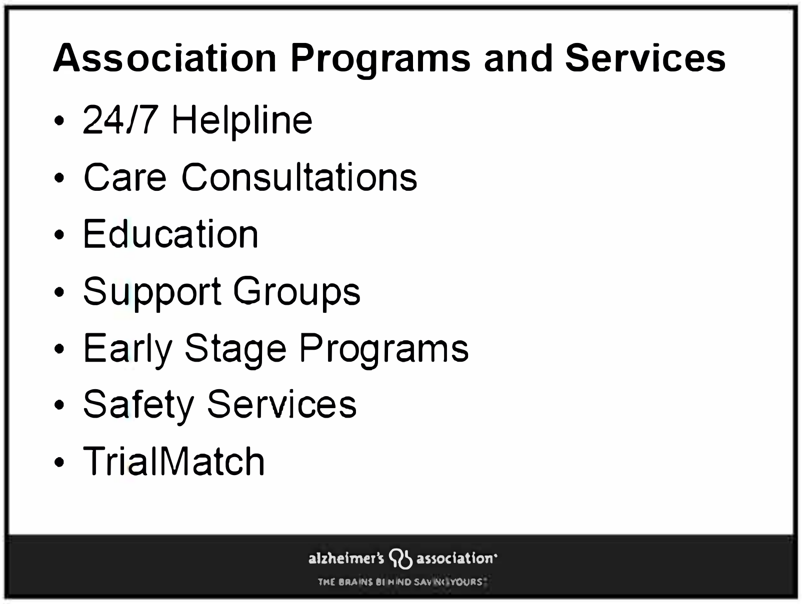

Association Programs and Services

- 24/7 Helpline
- Care Consultations
- Education
- Support Groups
- Early Stage Programs
- Safety Services
- TrialMatch

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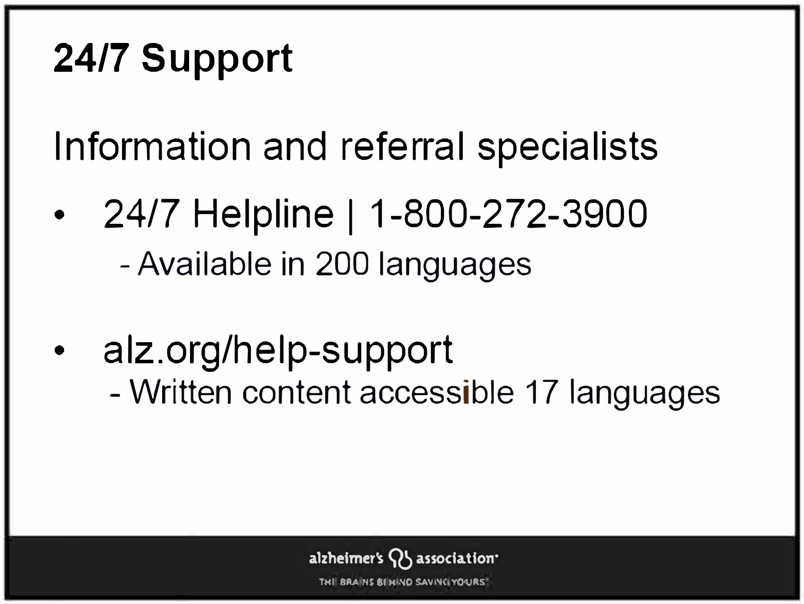

24/7 Support

Information and referral specialists

- 24/7 Helpline | 1-800-272-3900
  - Available in 200 languages
- alz.org/help-support
  - Written content accessible 17 languages

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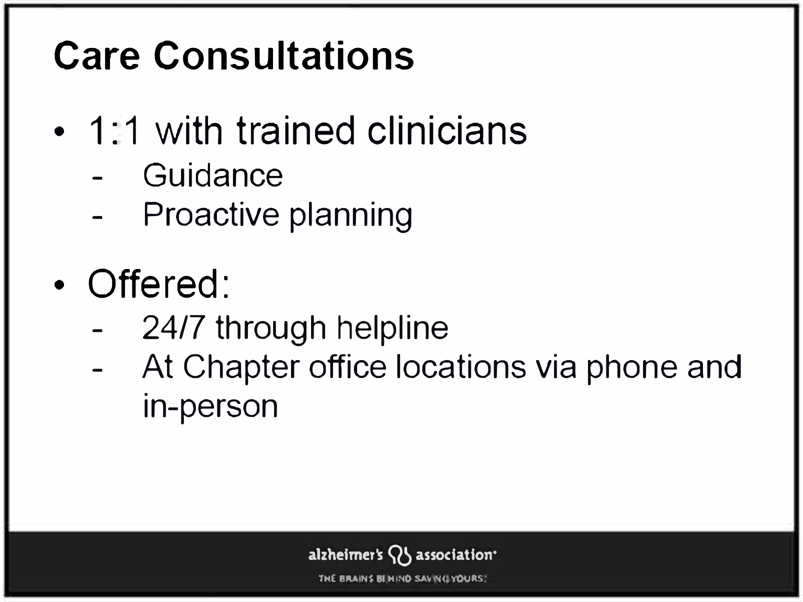

Care Consultations

- 1:1 with trained clinicians
  - Guidance
  - Proactive planning
- Offered:
  - 24/7 through helpline
  - At Chapter office locations via phone and in-person

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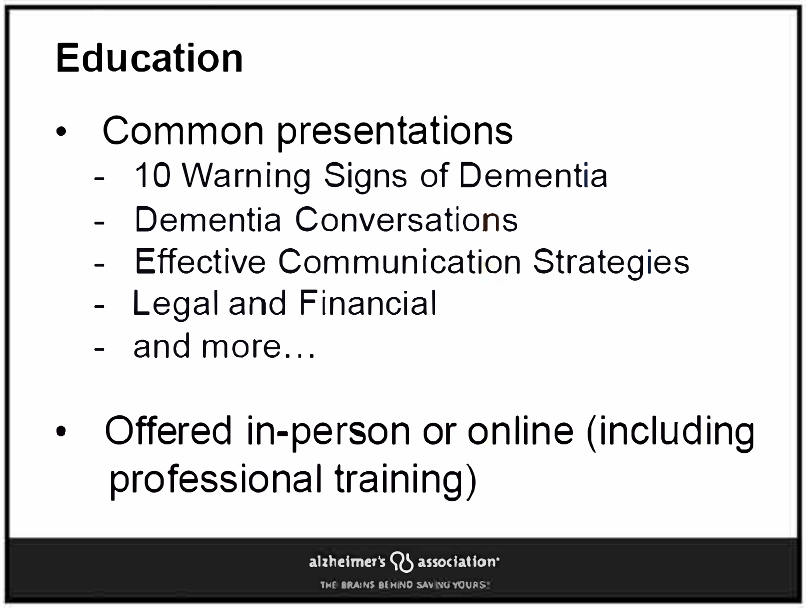

Education

- Common presentations
  - 10 Warning Signs of Dementia
  - Dementia Conversations
  - Effective Communication Strategies
  - Legal and Financial
  - and more…
- Offered in-person or online (including professional training)

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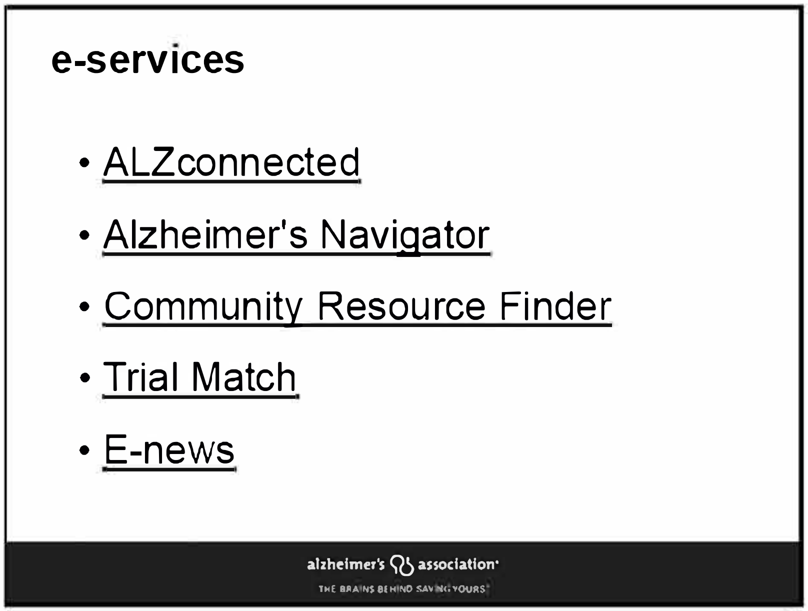

e-services

- ALZconnected
- Alzheimer's Navigator
- Community Resource Finder
- Trial Match
- E-news

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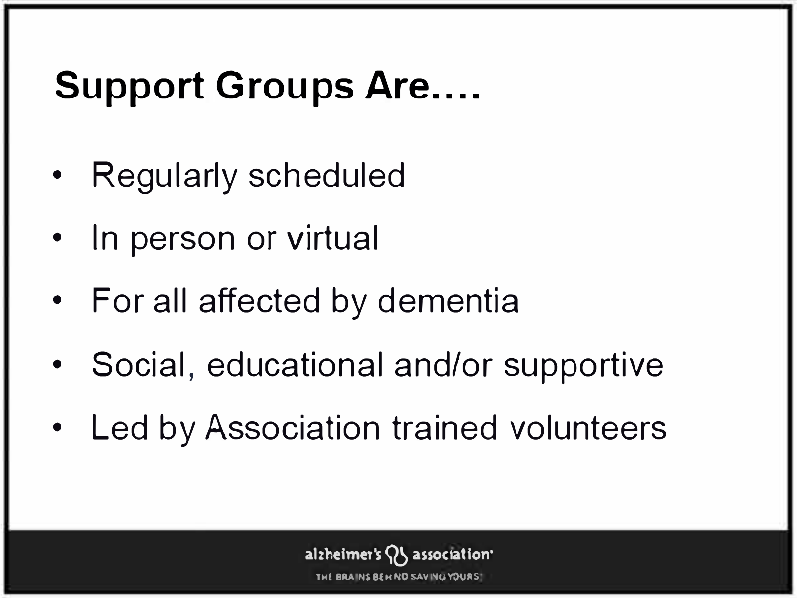

Support Groups Are….

- Regularly scheduled
- In person or virtual
- For all affected by dementia
- Social, educational and/or supportive
- Led by Association trained volunteers

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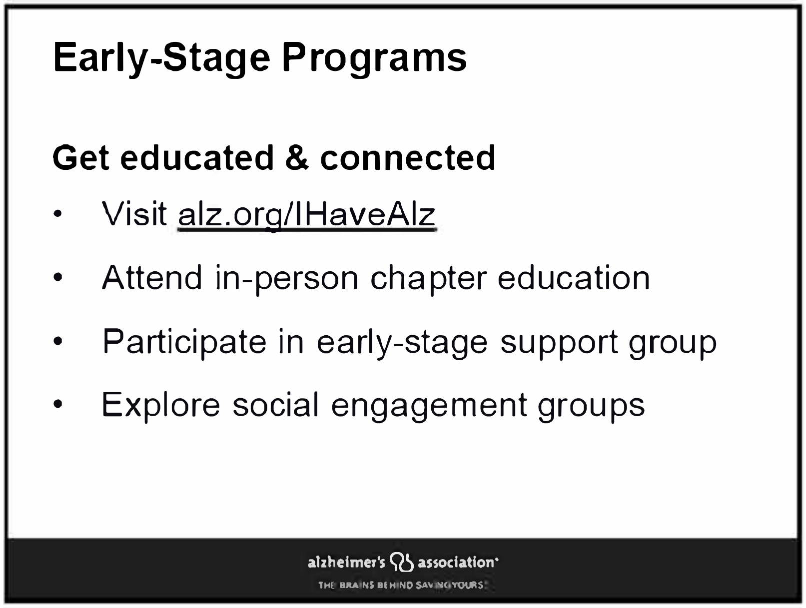

Early-Stage Programs

Get educated & connected

- Visit alz.org/IHaveAlz
- Attend in-person chapter education
- Participate in early-stage support group
- Explore social engagement groups

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Safety Services

In our Safety Center website **alz.org/safety**

- Wandering- MedicAlert®+SafeReturn®

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MedicAlert® + Alzheimer's Association Safe Return®

- Personalized emergency wallet card
- 24-hour emergency response service
- Personal health record (PHR)
- *Six Steps to a Safe Return* magnet

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Additional Safety Concerns…

- Home Safety
- Medication Safety
- Dementia and Driving Resource Center

And more… https://www.alz.org/help-support/resources/publications

*Doctors Visit Check List

*Documentation Guide

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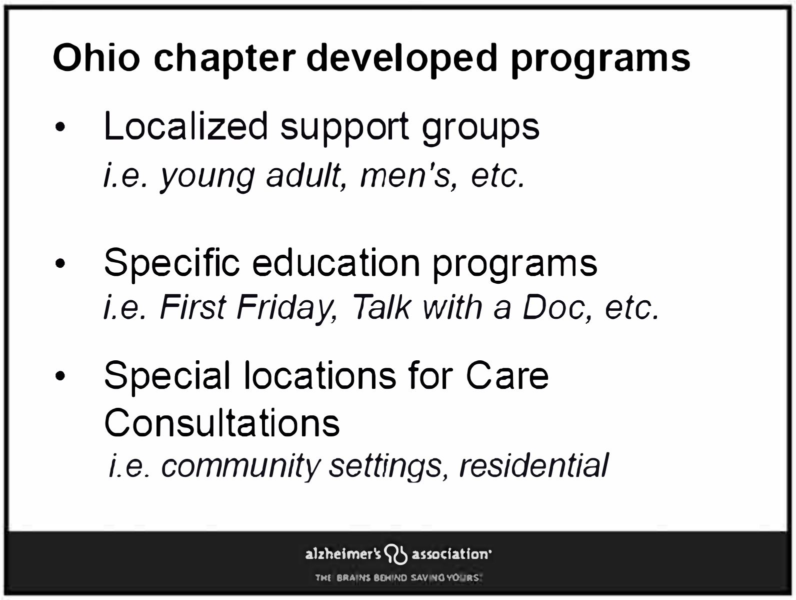

Ohio chapter developed programs

- Localized support groups
  i.e. young adult, men's, etc.
- Specific education programs
  i.e. First Friday, Talk with a Doc, etc.
- Special locations for Care Consultations
  i.e. community settings, residential

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Ohio chapter developed programs

- Early-stage engagement programs
  - Art *i.e. Memories in the Making*
  - Music *i.e. Day out Club*
  - Reminiscing *i.e. Memory Café*
- Community Collaborations
  i.e. Parkinson's Foundation, Hospitals, Area Agencies on Aging, local museums

*** listed on chapter specific websites***

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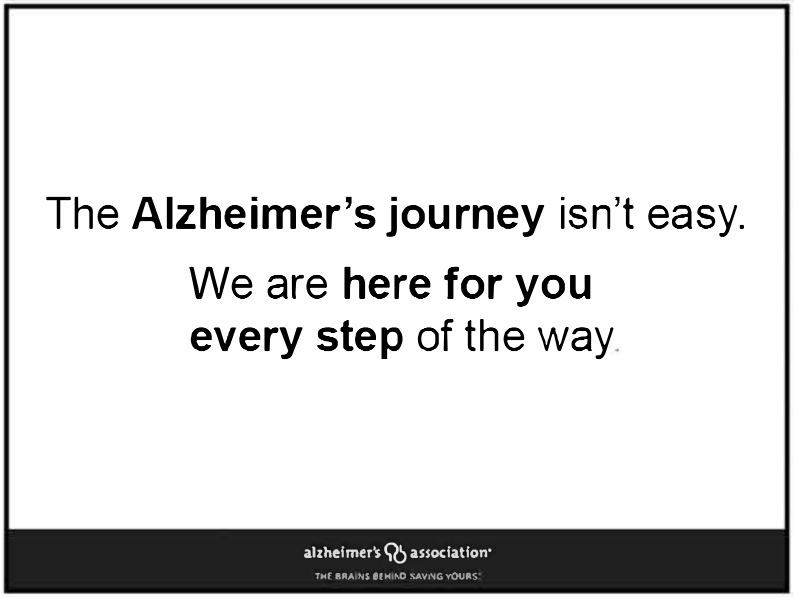

The **Alzheimer's journey** isn't easy.

We are **here for you**
every step of the way.

alzheimer's association

THE BRAINS BEHIND SAVING YOURS.

About the Alzheimer's Association®

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support and research. Founded in 1980 by a group of family caregivers and individuals interested in research, the Association includes our home office in Chicago, a public policy office in Washington, D.C., and a presence in communities across the country.

An estimated 47 million people worldwide are living with dementia. In the United States alone, more than 5 million have Alzheimer's, and 16 million are serving as their unpaid caregivers. The Association addresses this crisis by providing education and support to the millions who face dementia every day, while advancing critical research toward methods of treatment, prevention and, ultimately, a cure.

We provide care and support to those affected.

- Our free 24/7 Helpline (800.272.3900), staffed by master's-level clinicians and specialists, provides confidential support and information to all those affected in over 200 languages.
- Our website, alz.org®, is a rich resource designed to inform and educate multiple audiences, including those living with the disease, caregivers and professional health care providers.
- We conduct face-to-face support groups and educational programs in communities nationwide.
- We host ALZConnected®, an online community where people with Alzheimer's and their caregivers can ask questions and find support.
- Our innovative resources like LiveWell — online tools to empower those living with dementia to live well for as long as possible — help people build the confidence to face challenges and find their voice.
- Community Resource Finder, a comprehensive database of programs and services, housing and care services, and legal experts, allows people to locate resources in their communities.
- We offer MedicAlert® + Alzheimer's Association Safe Return®, a 24-hour nationwide emergency response service for individuals with Alzheimer's or other dementias.

We accelerate research and create a path for global progress.

- The Alzheimer's Association is the world's largest nonprofit funder of Alzheimer's research. Since 1982, our International Research Grant Program has committed over $410 million to nearly 2,700 best-of-field grant proposals, leading to exciting advances such as the development of Pittsburgh Compound B (PIB) which made amyloid buildup, a hallmark of Alzheimer's, visible in the living brain through a PET scan.
- We convene the dementia research community and help advance the field through the annual Alzheimer's Association International Conference® (AAIC®) and the Global Alzheimer's Association International Network (GAAIN), an online gateway to a vast collection of Alzheimer's research data.
- We play a key role in increasing knowledge about prevention. In 2018, to accelerate this field of study, the Association funded and implemented the U.S. POINTER study, a first-of-its-kind lifestyle intervention trial to prevent cognitive decline and dementia.
- We accelerate clinical studies through TrialMatch®, a free, easy-to-use clinical studies matching service for people with the disease, caregivers and healthy volunteers.

We advocate for the needs and rights of people facing Alzheimer's.

- Working with the Alzheimer's Impact Movement (AIM), the Association's advocacy arm, we assemble and train a nationwide network of advocates whose voices are critical in engaging elected officials.
- We help pass landmark legislation such as the National Alzheimer's Project Act, which mandated the creation of a national plan to fight Alzheimer's and coordinates efforts toward its first goal to prevent and effectively treat the disease by 2025.
- We strengthen the federal government's commitment to Alzheimer's research. In 2018, the Association and AIM helped secure a historic $414 million increase for Alzheimer's disease research funding.
- We secure quality health care services for those affected. The Alzheimer's Association and AIM were instrumental in a 2016 decision by the Centers for Medicare & Medicaid Services ensuring that people with Alzheimer's will have access to care planning with a medical professional through Medicare.

Learn more and join our cause. Visit alz.org.

TS-0001 | Updated April 2018

Dementia

Dementia is an overall term for diseases and conditions characterized by a decline in memory, language, problem-solving and other cognitive skills that affect a person's ability to perform everyday activities. This decline occurs because nerve cells (neurons) in parts of the brain involved in cognitive function have been damaged and no longer function normally. **Alzheimer's** is the most common type of dementia, accounting for 60 to 80 percent of cases. **Vascular dementia**, which occurs because of microscopic bleeding and blood vessel blockage in the brain, is the second most common type of dementia.

Other types and causes of dementia:

- Creutzfeldt-Jakob disease
- Mixed dementia
- Frontotemporal dementia
- Lewy body dementia/Dementia with Lewy bodies
- Normal-pressure hydrocephalus
- Parkinson's disease
- Pick's disease
- Progressive supranuclear palsy

Individuals with Down syndrome, Huntington's disease and Wernicke-Korsakoff syndrome are at risk for developing dementia symptoms.

Symptoms of dementia can vary greatly. Examples include problems with short-term memory, keeping track of a purse or wallet, paying bills, planning and preparing meals, remembering appointments and traveling out of the neighborhood.

In some cases, individuals do not have dementia but instead have a condition with symptoms that mimic those of dementia. Common causes of dementia-like symptoms are depression, delirium, side effects from medications, thyroid problems, certain vitamin deficiencies and excessive use of alcohol. Unlike dementia, these conditions may often be reversed with treatment.

A physician can help identify the specific cause of dementia and provide appropriate care.

TS-0052 | Updated June 2018

PROGRAMS AND SERVICES

NO MATTER WHERE YOUR ALZHEIMER'S JOURNEY TAKES YOU. WE ARE THERE FOR YOU.
The Alzheimer's Association is committeed to providing care and support for those impacted by the disease and have identified key programs and services to be offered in all 78 chapters across the country. The following programs are available to you and your loved one throughout the nation. All services are provided free. Check with your local chapter for more information.

24/7 HELPLINE | 800-272-3900

Day or night, whenever you need us. Reliable informatoin and support when you need it most. Available in more than 200 languages and dialects.

CARE CONSULTATIONS

Ongoing personalized coaching, resources and strategies to assist with decision making and care options.

SUPPORT GROUPS

Peer-or professionally led groups for caregivers, individuals living with Alzheimer's and others dealing with the disease. All support groups are facilitated by trained individuals.

EDUCATION

Online and in-person educational programs and publications on topics related to Alzheimer's disease and caregiver tools.

EARLY STAGE ENGAGEMENT PROGRAMS

The Alzheimer's Association early-stage engagement programs offer a comfortable way to get out, get active and get connected to others who are living in the beginning stage of Alzheimer's or other dementia.

SAFTEY SERVICES

Safety is important for everyone, but the need for a comprehensive safety plan becomes vital as dementia progresses. We offer a variety of resources to help you take measures to improve saftey of your loved one.

AROUND-THE-CLOCK INFORMATION AND SUPPORT

ALZHEIMER'S ASSOCIATION 24/7 HELPLINE: 800.272.3900

The free Alzheimer's Association® 24/7 Helpline allows people living with Alzheimer's disease or dementia, caregivers, families and the public to:

- Speak confidentially with master's-level care consultants for decision-making support, crisis assistance and education on issues families face every day.
- Learn about the signs of Alzheimer's and other dementias.
- Get general information about medications and other treatment options, and legal, financial and care decisions.
- Find out about local programs and services.
- Receive help in their preferred language through our bilingual staff or translation service, which accommodates more than 200 languages.
- Access support through our TTY service (TTY: 866.403.3073) if assistance is required via a teletype device.

This project was supported, in part by grant number 90AC2811-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

alzheimer's association®

800.272.3900 | alz.org®

e-Services

The Alzheimer's Association® is committed to helping individuals living with dementia and those who care for them as they face the disease. Our online resources and support make it possible for people to access information and tools wherever and whenever they need them.

alz.org® | alzheimer's association

We Can Help

When Alzheimer's touches your life, we are here for you.

---

alz connected® **You are not alone.**
alzconnected.org

FREE

ALZConnected®, powered by the Alzheimer's Association, is an online social networking community designed for people living with Alzheimer's disease or other dementias and their caregivers. Members can connect and communicate with others who understand their unique challenges. They can do so by posing questions and offering solutions to dementia-related issues, creating public and private groups organized around a specific topic, and contributing to message boards.

ALZHEIMER'S navigator®
alzheimer's association®

FREE

Map out a plan to approach Alzheimer's.
alz.org/alzheimersnavigator

A diagnosis of Alzheimer's raises many questions. Alzheimer's Navigator® helps guide individuals living with the disease and their caregivers to answers. This interactive online tool assesses users' needs to create customized action plans of information, support and local resources. Users can access guidance on a range of topics, including legal and financial planning, safety and daily living.

Find Alzheimer's disease-related services in your area.
alz.org/CRF

FREE

The Alzheimer's Association Community Resource Finder makes it easy for individuals with Alzheimer's, their caregivers and others involved in making care-related decisions locate dementia resources, programs and services in their area. With this online tool, powered by CareLike®, users can access a wide range of services to meet immediate needs and plan for the future, including housing and care at home options; legal, medical and community services; diagnostic centers; and Alzheimer's Association programs.

alz.org® • eservices@alz.org

alzheimer's association®

FREE

Alzheimer's and dementia online courses available 24/7.

alz.org/education

Because of the progressive nature of Alzheimer's, an individual living with the disease will require increasing levels of care over time. Learning what to expect and how to implement helpful care strategies can significantly improve quality of life for both the caregiver and the person living with dementia. The Association offers a variety of free educational workshops online and in communities nationwide, including:

- *Healthy Living for Your Brain and Body*
- *Know the 10 Signs: Early Detection Matters*
- *The Basics: Memory Loss, Dementia and Alzheimer's Disease*
- *Legal and Financial Planning for Alzheimer's Disease*
- *Living with Alzheimer's: For People with Alzheimer's*
- *Living with Alzheimer's: For Caregivers (Early, Middle and Late Stage)*
- *Effective Communication Strategies*
- *Understanding and Responding to Dementia-Related Behavior*
- *Dementia Conversations: Driving, Doctor Visits, Legal and Financial Planning*
- *Approaching Alzheimer's: First Responder Training*

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alzheimer's association
trialmatch®

FREE

Don't just hope for a cure. Help us find one.

alz.org/trialmatch

TrialMatch® is a free, easy-to-use clinical studies matching service that connects individuals with Alzheimer's, caregivers, healthy volunteers and physicians with current studies. The continually updated database contains more than 250 research studies currently being conducted at sites across the country and online. By participating in clinical research, everyone can help accelerate progress and provide valuable insight into potential treatments and methods of prevention.

For more information:

Email: **eservices@alz.org**
Phone: **800.272.3900**
Online: **alz.org/care** and **alz.org/IHaveAlz**
Resources in your community: **alz.org/CRF**

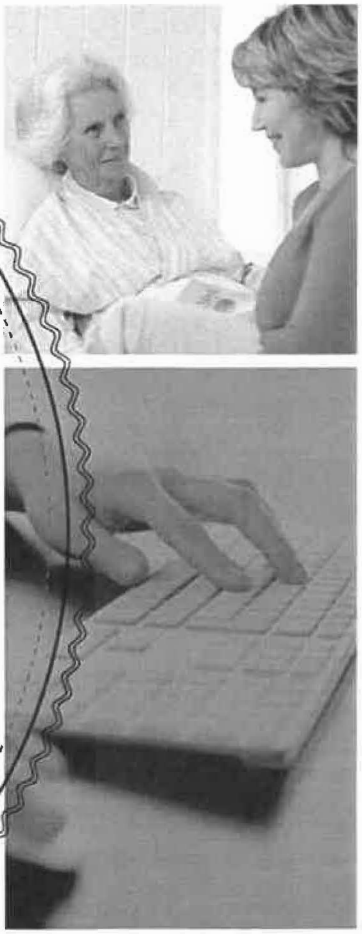
alzheimer's association®

800.272.3900 | alz.org®

YOU CAN'T PREVENT

ALZHEIMER'S

BUT YOU CAN AVOID SOME OF ITS DANGERS.



Taking safety precautions is important when caring for those with Alzheimer's disease or dementia. Our safety center at alz.org/safety provides important safety tips and guidance to help you keep those with Alzheimer's safer.

alz.org/safety

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alzheimer's association®

MEDICALERT + SAFE RETURN

MedicAlert® + Alzheimer's Association Safe Return® 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

If an individual with Alzheimer's or a related dementia wanders and becomes lost, caregivers can call the 24-hour emergency response line (800.625.3780) to report it.

A community support network will be activated, including local Alzheimer's Association® chapters 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 person's MedicAlert + Safe Return ID jewelry. MedicAlert + Safe Return will notify the listed contacts, making sure the person is returned home.

Cost and ID jewelry

MedicAlert + Safe Return provide an ID bracelet or pendant to be worn by the individual with dementia.
$55 + $7 shipping and handling, you receive an enrollment package including:

- Member's ID jewelry with personalized information and MedicAlert + Safe Return's 24-hour emergency toll-free number
- Personalized emergency wallet card
- 24-hour emergency response service
- Personal health record (PHR)
- Six Steps to a Safe Return magnet

(Optional) Add $35 for caregiver ID jewelry and membership
Membership includes everything listed above
The caregiver wears this worldwide-recognized ID jewelry to alert others that he or she provides care for a MedicAlert + Safe Return member, in case of an emergency

An annual fee of $35 will be due after the first year for each membership.

Join

There are four easy ways to join MedicAlert + Safe Return:

1. **Online:** www.medicalert.org/safereturn
2. **Call:** 888.572.8566
3. **Mail:** Complete and mail in the enrollment form.
   Completed enrollment form and photos can be mailed to:
   MedicAlert + Alzheimer's Association Safe Return PO Box 21009 Lansing, MI 48909
4. **Fax:** Registration form to 800.863.3429

**Don't just hope for a cure.
Help us find one.**

alz.org/TrialMatch

alzheimer's association
trialmatch

powered by EmergingMed

About TrialMatch.

Alzheimer's Association TrialMatch® is a free, easy-to-use clinical studies matching service for individuals living with dementia, caregivers and healthy volunteers without dementia. TrialMatch — and its database of more than 250 studies taking place across the country and online — is your opportunity to learn about current Alzheimer's research opportunities.

How does TrialMatch work?

1. Create a free account.
2. Answer a few questions to complete a profile for yourself and/or additional family members.
3. Receive a customized list of potential study matches.
4. Decide if you wish to contact any of the studies. TrialMatch will keep your information confidential and you are under no obligation to contact or participate in any study.

Ready to learn more?

Contact TrialMatch in the way that works best for you.

- » Visit alz.org/TrialMatch
- » Email TrialMatch@alz.org
- » Call 800.272.3900
- » Complete and return this card to an Association representative or mail to:

Alzheimer's Association
Attn: TrialMatch
225 N. Michigan Ave., Fl. 17
Chicago, IL 60601

Fill out this card and we'll be in touch. However, there's no need to wait. Visit **alz.org/TrialMatch** or call **800.272.3900** anytime to learn about potential research opportunities.

Name: ____________________

Email: ____________________

Phone: ____________ ZIP code: ____________

Contact me by: ☐ Email ☐ Phone

alzheimer's association
trialmatch

powered by EmergingMed

QUICK LINKS

Alzheimer's Association - **alz.org**

Alzheimer's Association blog **- alz.org/blog**

Alzheimer's Association e-news sign-up **- alz.org/enews**

Alzheimer's Association International Conference (AAIC) **- alz.org/aaic**

Alzheimer's Association Publications**- alz.org/help-support/resources/publications**
i.e. Doctor visit checklist-**alz.org/media/Documents/doctor-visit-checklist.pdf**

ALZConnected **- alzconnected.org**

Alzheimer's Facts and Figures **- alz.org/alzheimers-dementia/facts-figures**

Advocacy Forum **- alz.org/forum**

Alzheimer's Impact Movement (AIM) **- alzimpact.org**

Alzheimer's Navigator **- alzheimersnavigator.org**

Caregiver resources - **alz.org/help-support/caregiving**

Community resource finder - **communityresourcefinder.org**

Glossary - **alz.org/help-support/caregiving/care-options/glossary**

Safety resources **- alz.org/help-support/caregiving/safety**
MedicAlert® + Alzheimer's Association Safe Return®
alz.org/help-support/caregiving/safety/medicalert-safe-return

TrialMatch **-trialmatch.alz.org**

Virtual Library - **alz.org/help-support/resources/virtual_library**
Connect with the Green-Field Library
Phone: 800.272.3900 (ask to be transferred to the Green-Field Library)
Email: greenfield@alz.org

The Longest Day **- alz.org/tld**

Walk to End Alzheimer's **- alz.org/walk**

OHIO CHAPTERS

Central Ohio Chapter **- alz.org/centralohio**

Cleveland Area Chapter **- alz.org/cleveland**

Greater Cincinnati **- alz.org/cincinnati**

Greater East Ohio Area Chapter **- alz.org/akroncantonyoungstown**

Miami Valley Chapter **- alz.org/dayton**

Northwest Ohio Chapter **- alz.org/nwohio**

alzheimer's association®

OHIO CHAPTERS

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Central Ohio Chapter

Connect with us at two office locations
Web: alz.org/centralohio

Columbus main office
1379 Dublin Road
Columbus, OH 43215
614-457-6003

Delaware County office
39 West Winter Street
Delaware, OH 43015
740-363-1365

Service area: Delaware, Fairfield, Fayette, **Franklin**, Hocking, Licking, Madison, Marion, Morrow, Perry, Pickaway, Pike, Ross and Union counties.

Cleveland Area Chapter

Connect with us at three locations
Web: alz.org/cleveland

Cleveland main office
23215 Commerce Park Dr., Suite 300
Beachwood, OH 44122
216-342-5556

Lake County office
8522 East Ave.
Mentor, OH 44060
800-272-3900

Lorain County office
37309 Harvest Dr.
Avon, OH 44011
800-272.3900

Service area: Ashtabula, **Cuyahoga,** Geauga, **Lake** and **Lorain** counties

Greater Cincinnati Chapter

Web: alz.org/cincinnati

Hamilton County main office
644 Linn St # 1026
Cincinnati, OH 45203
513-721-4284

Jackson County office
644 Linn St # 1026
Cincinnati, OH 45203
513-721-428

Butler County office
5180 Cedar Village Drive, Suite C,
Mason, OH 45040

Service area: Adams, Brown, **Butler**, Clermont, Clinton, Gallia, **Hamilton**, Highland, **Jackson,** Lawrence, Scioto, Vinton, Warren counties.

Greater East Ohio Area Chapter

Connect with us at three office locations
Web: alz.org/akroncantonyoungstown

Akron area office
Service area: Summit, Medina, and Portage counties
70 W. Streetsboro St., Suite 201
Hudson, OH 44236
330-650-0552

Canton area office *(by appointment.)*
Service area: Carroll, Coshocton, Holmes, Muskingum, **Stark**, Tuscarawas, and Wayne counties.
408 Ninth St. SW, Suite 1610
Canton, Ohio 44707
330-966-7343

Youngstown area office *(by appointment.)*
Service area: Belmont, Columbiana, Guernsey, Harrison, Jefferson, **Mahoning**, and Trumbull counties
3695B Boardman-Canfield Rd., Suite 301
Canfield, Ohio 44406
330-533-3300

OHIO CHAPTERS

alzheimer's association®

Miami Valley Chapter

Web: alz.org/dayton

Dayton office

31 W Whipp Rd
Dayton, OH 45459
Phone: 937-291-3332

Service area: Champaign, Clark, Darke, Greene, Logan, Miami, **Montgomery**, Preble, Shelby counties.

Northwest Ohio Chapter

Connect with us at three locations
Web: alz.org/nwohio

Toledo area main office

Service area: Defiance, Erie, Fulton, Henry, **Lucas**, Ottawa, Sandusky, Williams, and Wood counties
480 Dussel Dr.
Maumee, OH 43537
419-537-1999

Findlay-Lima area office

Service area: Allen, Auglaize, **Hancock**, Hardin, Mercer, Paulding, Putnam and Van Wert counties
1800 N Blanchard St., Suite 128
Findlay, OH 45840
419-425-5409

Mansfield area office

Service area: Ashland, Crawford, Huron, Knox, **Richland**, Seneca and Wyandot counties
2131 Park Avenue West
Ontario, OH 44906
419-522-5050

West Virginia Chapter

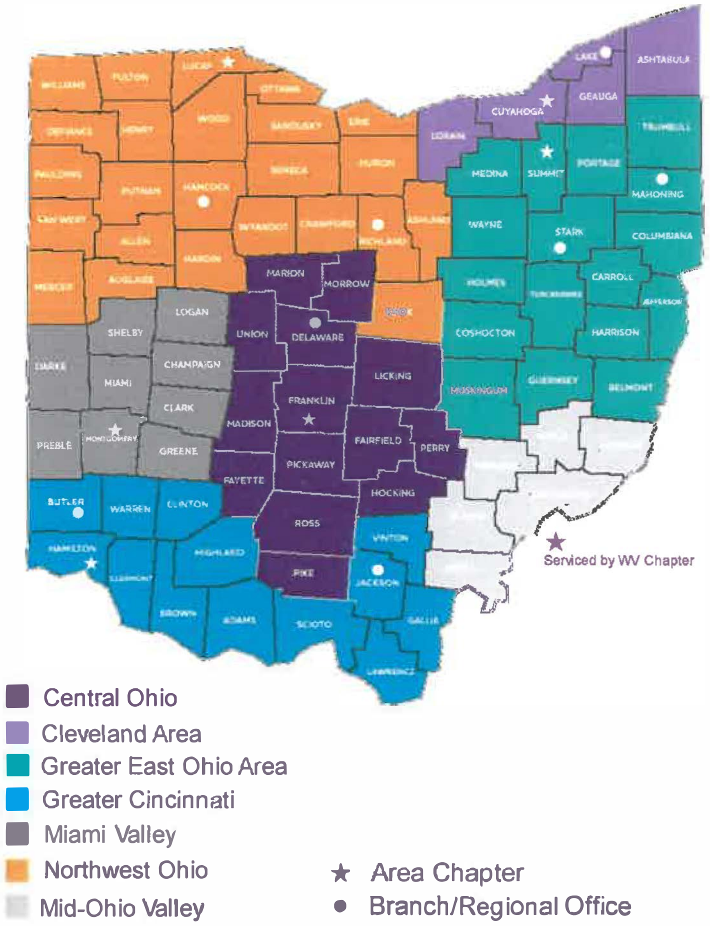
Connect with us at three locations
Web: alz.org/nwohio

Charleston office serving Ohio

1601 2nd Avenue
Charleston, WV 25387
304-343-2717

Ohio serivce area: Athens, Meigs, Morgan, Monroe, Noble and Washington counties.

ALL ACROSS OHIO,
WE ARE HERE TO HELP.



Notes:

The Supreme Court *of* Ohio
Judicial College