Dementia 101: What Every APS Worker Needs to Know about Dementia/Neurocognitive Disorders

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About the APS TARC

The mission of the APS TARC is to enhance the effectiveness of state APS programs by:

- Supporting federal, state, and local partners’ use of data and analytics,
- Applying research and evaluation to practice, and
- Encouraging the use of innovative practices and strategies.
Peer to Peer Calls

Have you ever wished that you could tap into the expertise of other APS workers, supervisors or state administrators who are struggling with the same issues and concerns that you deal with daily? The APS TARC provides Peer to Peer calls for workers, supervisors and managers/state administrators.

- **Workers’ Call**: The 2nd Wednesday of each month
- **Supervisors’ Call**: The 3rd Wednesday of each month
- **Administrators’/Managers’ Call**: The 4th Wednesday of each month

Register via the link sent out at the end of each month by the APS TARC or email us in order to receive the registration link!
APS & COVID-19


• Resource Information
• Federal brief addressing:
  ▪ Personal Safety
  ▪ Continuity of Operations
• Summary of State Program and Policy Responses to COVID-19
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Quick Attendee Poll

Which of the following do you identify the most with?

- Adult Protective Services Professional
- Other Social Services Professional
- Medical Professional
- Legal Professional
- Other
I am a licensed Geropsychologist in private practice in Sacramento since 1985. After graduating from Yale University, I completed my doctorate in clinical psychology at University of California, Davis. During my pre and postdoctoral internships, I focused on the neuropsychology of aging and trained in the Department of Community Health Geriatric Clinic, which later developed into the UC Davis Alzheimer’s Disease Center. I am past President of Sacramento Psychological Association (SVPA) and current President of the SVPA Forensic Division. I am an active member of the Section of Geropsychology in the Division of Clinical Psychology of the American Psychology Association, and of Psychologists in Long Term Care, for which I served as past editor of their newsletter. I am also a founding member of the Sacramento Financial Abuse Specialist Team and Elder Death Review Team. Advocating for the best interest of elders is my top priority. I approach complex personal and professional ElderCare problems in a practical, thoughtful, and direct manner. As an ElderCare Adviser to legal, health, financial, social service, and law enforcement professionals throughout California, I consult and train those serving elders.
Dementia 101: What Every APS Worker Needs to Know about Dementia/Neurocognitive Disorders

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My work is guided by the principle that elders have the rights to:

- **Advocacy** for their best interests
- **Safety** in pursuing health, housing, financial, and daily living activities
- **Freedom** to make informed decisions unless their capacity is compromised
- **Aging in place** with the least disruptive, intrusive, and restrictive interventions
- **Optimal functioning** with the highest level of independence, dignity, and grace
Learning Objectives

• The Good, the Bad, and the Ugly
  ▪ Neurocognitive Changes/ Risks
  ▪ Alzheimer’s Disease
  ▪ Differentiating Types of Dementia
  ▪ Reversible Dementias

• Field Tested Rapid Assessment Screens

• Mental Capacity and Dementia
Older Adults Demographics

> 65y.o. (20% of US population, in 2050)

- Longevity is 79 yrs (women + 5yrs, blacks - 5yrs)*
- 1/3 live alone, 2/3 live with/ near family
- 5+ million with AD currently, 15 million by 2050**
- Control 70% of total net worth in U.S

- Fastest growing segment of population +85y.o*
  - 75-84 y.o. + 5% of US Population
  - 85-100 y.o. + 2% of US Population

* Census Bureau, Current Population Report, 2/2020
**Alzheimer’s Association, Website, 2020
Primary Standards of Intervention

1) Best Interests of Elder
2) Right of **Self Determination**
   
   Need for Primary Control

3) Maximize **Safety**
   
   Need for Personal Protection

4) Optimize Functioning
5) Aging in Place

   Least Intrusive, Disruptive, Restrictive Alternatives
Normal Cognitive Decline with Age

- Processing Speed
- Arithmetic Skills
- Working Memory
- Executive Functions
- Inhibition > Distractibility/ Impulsivity
Neurocognitive Risks

Advancing Age

The 3 D’s
- Dementia (NeuroCognitive Disorders)
- Delirium
- Depression

Medical Conditions
Medication Mismanagement/ Polypharmacy

Lifestyle (Sleep, Diet, Physical Activity)

Social Isolation
- Substance Abuse
- Elder Abuse
Primary Risks The 3 D’s

- Dementia
- Depression
- Delirium
Dementia
Neurocognitive Disorders (DSMV)

• Evidence of significant cognitive decline
  ▪ Concern of person, informant, or clinician
  ▪ Impairment in cognitive performance

• The cognitive deficits effect independence

• Deficits not due to delirium/mental disorder

• Mild Impairment
  ▪ Modest/continued independence

• Major Impairment
  ▪ Substantial/interrupted independence
Deficits Effect Independence
Behavioral Red Flags

Repeated and Progressive Problems with:

Instrumental - IADL’s
- Transportation (Driving)
- Financial Management
- Medication Management
- Shopping
- Preparing Food
- Housework
- Using Communication Devices

ADL’s
- Bathing
- Grooming
- Dressing
- Feeding
- Continence
- Ambulate/Transfer
Mild Cognitive Impairment (MCI)
Mild Neurocognitive Disorder

Generalized slowing of Encoding/ Retrieval (1-2 sd)

- Rapid Forgetting/ Short Term Learning
- Delayed Recall (Word List Learning, Paragraph Memory)
- Language/ Verbal Fluency (Naming, Categories)
- Not Demented (Insufficient functional impairment)
- 25 -50% convert to dementia within 5 years
Cognitive Criteria for Diagnosis of Dementia (NeuroCognitive Disorder)

• Impairment in one or more of these 6 domains:
  ▪ Impaired Short-Term Memory/ New Learning
  ▪ Complex Attention/ Concentration
  ▪ Expressive Language/ Fluency & Naming (Agnosia)
  ▪ Visuoperceptual Motor (Apraxia)
  ▪ Executive Functions
  ▪ Social Cognition (Emotional Recognition)

• Clear Sensorium

• Typical Pattern of Onset

• Comorbidity with Depression/ Delirium
Executive Functioning

Cognitive Signs
- Inhibition and Control/ Monitoring Responses
- Working Memory/ Combining Words and Visuals
- Planning, Sequencing, and Organizing/ Categorizing
- Cognitive Flexibility/ Multitasking

Behavioral Signs of Dysfunction
- Imitation and Perseveration
- Impaired Working Memory
- Impaired Organization and Implementation
- Tactlessness, Impulsivity, Aggressiveness
Social Cognition

- Cognition of Emotions
- Social/ emotional recognition/ memory
- Comprehension of Social Interactions
- Insensitivity to Social Standards
- Poor Interpersonal Control
Distribution of Dementia*

*National Alzheimer’s Project Act (NAPA), Meeting of Advisory Council, April 29, 2016

- Alzheimer's: 56%
- Cerebrovascular Causes: 14%
- Cerebrovascular Causes: 14%
- Parkinson's: 8%
- Brain Injury: 4%
- Multiple Causes: 12%
- Other Causes: 6%
Alzheimer’s Disease (AD)

• Intact basic attention in the early stages

• ST & Delayed Memory Impairment:
  ▪ abnormally rapid decay from memory stores

• Progressive Deficits
  ▪ Language - Naming and Verbal Fluency
  ▪ Executive Functions
  ▪ Visuospatial Dysfunction
  ▪ Poor Orientation/ Complex Attention
Basal Forebrain
Large numbers of nerve cells (neurons) containing Acetylcholine:
• Learning
• Remembering

Hippocampus
Area of the brain important for the formation and storage of memories.
AD - Brain Pathology

Tau - Neurofibrillary Tangles
Amyloid - Plaques
Which is the brain with AD (poll)

- Top
- Bottom
# Chronic Disease Stages of AD

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<th>Latent Phase</th>
<th>Malignant Phase</th>
<th>Diagnosis</th>
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<td>&gt; Age</td>
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<tr>
<td>Physical Inactivity</td>
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Staging Alzheimer’s Disease

- **AD brain changes** start decades before symptoms show.
- **Amnestic MCI**: memory problems; other cognitive functions OK; brain compensates for changes.
- **Cognitive decline** accelerates after AD diagnosis.

Graph showing:
- Normal age-related memory loss.
- Total loss of independent function.

Legend:
- Healthy Aging
- Amnestic MCI
- Clinically Diagnosed AD
Differentiating Types of Dementia Typical Patterns of Onset/ Course

- Alzheimer’s Disease – onset >age, gradual course
- Parkinson’s – onset >age, gradual course
  cognitive deficits follow motor deficits
- Vascular – sudden onset/ gradual course
  cerebrovascular events, executive dysfunction/ depression
- Lewy Body – onset > age, rapid course
  attention and alertness (delirium like), visual hallucinations,
  parkinsonism (after cognitive decline), Intact ST memory
- Frontotemporal- early onset (< 65), rapid course behavioral/ language variants; social cognition/ executive functions, Intact ST memory
Questions
Reversible Dementias (Reversible Medical Conditions)

- Depressive/ Delirium Pseudodementia
- Drug Toxicity (polypharmacy, drug interactions)
- Cardiovascular/ Thoracic Complications
- Nutrition/ Metabolic/ Endocrine
- Tumors/Trauma
- Infections (UTI)
- Sensory Problems (vision, hearing)
- Nutritional Problems
- Chronic Pain
- Insomnia
- Drugs
Depression (Pseudomentia)

- Sleep Problems
- Loss of Energy
- Change in Appetite/ Weight
- Psychomotor Retardation/ Agitation
- Anhedonia - Loss of Interest in Usual Activities
- Suicidal Ideation
- Cognitive Symptoms of Dementia (Reversible)
  - Concentration/ Attention
  - Short Term Memory
  - Verbal Dysfluency
  - Slow Processing Speed
  - Executive Dysfunction
Which is the most prominent symptom of Elder Depression (poll)

- Sleep Problems
- Loss of Energy
- Change in Appetite/ Weight
- Anhedonia - Loss of Interest in Usual Activities
- Suicidal Ideation
Geriatric Depression Scale - short form (GDS)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / NO
2. Have you dropped many of your activities and interests? YES / NO
3. Do you feel that your life is empty? YES / NO
4. Do you often get bored? YES / NO
5. Are you in good spirits most of the time? YES / NO
6. Are you afraid that something bad is going to happen to you? YES / NO
7. Do you feel happy most of the time? YES / NO
8. Do you often feel helpless? YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO
10. Do you feel you have more problems with memory than most? YES / NO
11. Do you think it is wonderful to be alive now? YES / NO
12. Do you feel pretty worthless the way you are now? YES / NO
13. Do you feel full of energy? YES / NO
14. Do you feel that your situation is hopeless? YES / NO
15. Do you think that most people are better off than you are? YES / NO

ANSWERS IN BOLD = ONE POINT EACH.

Scoring: 0-4 = NML  5-9 = MILD  10+ = MODERATE TO SEVERE

Answers in bold indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score > 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression.

http://www.stanford.edu/~yesavage/GDS.english.short.score.html
Delirium- Acute Confusional State (Pseudodementia)

- Cognitive Deficits
  - Disorientation
  - Memory Loss
  - Language
  - Visuoperceptual
- Hallucinations/ Delusions
- Rule Out Intoxication/ Withdrawal
- Consequence of a Medical Condition/ Trauma
  - Infection, Meds, Substance, Pain, Relocation
Dementia Screening

• Self Report and Presentation
• Collateral Reports
  ▪ Spouse, children, caregivers, professionals
• Red Flags/ Patterns/ Recent Incidents
  ▪ Independence < IADLs > Assistance
  ▪ Accidents – Driving, Falling, ER visits, Lost
  ▪ Cognition > Forgetting < Executive Function
  ▪ Language > Repetition < Articulation
  ▪ Psychosocial > Irritability > Agitation
This tool is available as a handout in your GoToWebinar Control Panel.
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Clock Drawing

Draw a clock and set the hands to show 10 minutes past 11.

Copy this clock below.
Clock Drawing: Free Condition
Dementia Significantly Compromises the Mental Capacity to Make Legal Decisions

Processing a Risk/ Benefit analysis

- Testamentary
  - Create or change a will/ trust
- Medical
- Financial
- Independent Living
Decisional Capacity*
*Assessment of Older Adults with Diminished Capacity, American Psychological Association, 2008

To Consent to an Act, a Person Must Possess the Mental Capacity to Make an Intelligent Choice

• Understanding/ Comprehending Pertinent Issues

• Reasoning/ Rationale for the Decision

• Appreciating Ramification of Decisions (Integrating, Analyzing, Manipulating Information)

• Expressing a Choice
There is a Significant Safety Risk with the Presumption that Older Adults with Dementia Possess Mental Capacity
GC 335 California “Capacity Dec” Form

A. Attention and Orientation

B. Basic Mental Functions
1. Memory: Immediate Recall, Short-, Long-Term
2. Language: Understanding/Communicating
3. Language: Naming Familiar Objects and Persons
4. Understanding and Appreciating Quantities

Executive Functions
5. Reasoning with Abstract Concepts
6. Plan, Organize, and Carry Out Actions in Self-Interest
7. Reason Logically

C. Thought Disorders

D. Mood Disorders
Dementia Significantly Increases the Risk of Elder Abuse

Self-Neglect
• >50% Elder Abuse cases
• Socially isolated
• NeuroCognitive Disorders
• Depression
Example of Self Neglect – Severe Hoarding
Dementia Significantly Increases the Risk of Financial Abuse

• Vulnerable Elder with Assets
• Another Person appeals to vulnerability
  ▪ establishes a “Hook”, “Trust me. . .”
• Scams, Charm, Intimidation, Secretiveness
• Transfer of Assets

Compromised Financial Capacity with AD*
• 50% of persons with mild AD and
• 93% of persons with moderate AD

*A New Tool for Assessing Financial Decision Making Abilities in Older Adults, NAPSA, 2016
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