

SafeAssign Originality Report

DNP Project III Master Su 19 · Plagiarism Checker

[View Originality Report - Old Design](#)

Raquel Garcia Priestly

Submission UUID: 474d998-082f-d270-a77d-3565a25470e6

Total Score:  Medium risk 29 %

Total Number of Reports

1

Highest Match

29 %

Garcia-Priestly_Raquel_Dementia_Toolkit_Final.pdf

Average Match

29 %

Submitted on

08/10/19

08:56 AM CDT

Average Word Count

15,767

Highest: Garcia-Priestly_Raquel_Dementia_Toolkit_Final.pdf

Attachment 1 29 %

Internet (14)

23 %

- 2 alz
- 19 hhs
- 3 hhs
- 7 bib
- 11 springerpflege
- 1 alz
- 10 springermedizin
- 12 alz
- 8 chestervetclinic
- 9 hhs
- 4 wsimg
- 5 hhs
- 6 hta
- 18 psychiatrienet

Global database (11)

6 %

- 16 Student paper
- 23 Student paper
- 25 Student paper
- 26 Student paper
- 22 Student paper
- 21 Student paper
- 13 Student paper
- 15 Student paper
- 20 Student paper
- 24 Student paper
- 14 Student paper

Scholarly journals & publications (1)

0 %

- 17 ProQuest document

Top sources (3)

- 2 alz
- 1 alz
- 16 Student paper

Excluded sources (0)

1

1 Implementing a Cognitive Impairment Care Planning Toolkit to Enhance Dementia Care: A Quality Improvement Project

by

Raquel Garcia-Priestly

APPROVED BY DNP PROJECT ADVISOR / CLINICAL MENTOR:

Dr. Danielle Gunter, PhD, RN, CPN

2

ACKNOWLEDGEMENTS

Foremost, I would like to thank my project advisor Dr. Danielle Gunter PhD, RN, CPN for her assistance during this project. Without her guidance and patience this project would have been something different than what my initial desire was in helping this special population. I would also like to thank Dr. Denise Canchola, DNP, PMHCNS, BC for her persistence in pushing this project forward, and Arturo E. Freyre III, LPCS, RN for his valuable time. All have helped in making this project successful, for "alone we can do so little; together we can do so much"- Helen Keller.

Raquel Garcia-Priestly

3

① TABLE OF CONTENTS

LIST OF TABLES6

LIST OF FIGURES7

ABSTRACT8

STATEMENT OF THE PROBLEM10

Background and Significance11

ASSESSMENT13

Microsystem Assessment13

Needs Assessment15

Organization's Readiness for Change17

PROJECT IDENTIFICATION18

Purpose18

Objectives18

SUMMARY AND STRENGTH OF THE EVIDENCE19

Cognition.....20

Function21

Stage of Cognitive Impairment and Decision-Making Capacity22

Neuropsychiatric Symptoms (NPS)23

Depression.....24

Medication Review and Reconciliation25

Safety26

☺ Caregiver Identification and Needs Assessment	26
Advanced Care Planning (ACP)	28
4	
METHODS	29
Project Intervention	29
Step 1	29
Step 2	30
Step 3	30
Step 4	31
Step 5	32
Organizational Barriers and Facilitators	35
Ethical Considerations	36
RESULTS	37
Outcome 1	38

Outcome 2	39
Outcome 3	40
Outcome 4	40
DISCUSSION	41
Limitations	42
Recommendations	42
Implications for Practice	43
REFERENCES	45
APPENDICES	51
Appendix A Letter of Support	51
Appendix B Medication List	52
② Appendix C Dementia Severity Rating Scale (DSRS)	53
5	
① Appendix D KATZ Index of Independence in Activities of Daily Living	58
Appendix E Lawton-Brody Instrumental Activities of Daily Living	59

Appendix F My Stress Thermometer60

Appendix G Patient Health Questionnaire (PHQ-9)61

Appendix H Caregiver Profile62

Appendix I VAMC SLUMS Examination63

① Appendix J Neuropsychiatric Inventory Questionnaire (NPI-Q)64

Appendix K Safety Assessment Checklist66

Appendix L End-Of-Life Checklist67

Appendix M Decision Making Capacity68

Appendix N Resources- National and Local69

6

LIST OF TABLES

Table Page

1. Table 1 Summary of Toolkit Contents.....31

2. Table 2 Demographic Characteristics of Patients37

3. Table 3 Summary Characteristics of Caregivers38

4. Table 4 Identified Needs and Referrals40

7

LIST OF FIGURES

Figure Page

1. Figure 1 Comprehensive Cognitive Impairment Assessment Algorithm33

2. Figure 2 Screened Patients39

8

Abstract

Background: Alzheimer’s is the most expensive disease in the United States with costs reaching \$277 billion a year and affecting 5.7 million Americans. By 2050, 14 million Americans will

③ have Alzheimer’s disease and related dementias (ADRD). This burdensome disease not only affects the individual, but also those who are responsible for their care, making it extremely

complex to manage. Purpose: To systematically integrate the Alzheimer’s Association’s

① Cognitive Impairment Care Planning Toolkit in an outpatient mental health clinic to enhance care by effectively addressing the needs of patients with ADRD and of their caregivers.

Objectives: Increase the number of patients with ADRD and/or their caregivers screened using

...selected, increase the number of patients with needs and/or their caregivers selected using the validated, standardized assessment tools found within the toolkit; increase the number of patients and/or caregivers who were identified as having unmet need(s) that received appropriate follow-up referrals; increase the number of written care plans formulated from the comprehensive assessment; and increase revenue by utilizing billing CPT code 99483. Results: Conducting a person-centered comprehensive assessment and care plan was beneficial in enhancing care by addressing the complex needs of this population. It helped identify needs such as neuropsychiatric symptoms, patient and caregiver depression, functional and environmental safety concerns, and caregiver stress. It also improved documentation for care planning, and increased revenue collection.

Implications for practice: This toolkit allowed for holistic management of patient outcomes. Clinicians were able to customize treatment plans to tailor individual patient needs from to the multi-component assessments.

KEY WORDS

cognitive impairment, dementia, treatment planning, interventions, assessments

9

① Implementing a Cognitive Impairment Care Planning Toolkit to Enhance Dementia Care: A Quality Improvement Project

Alzheimer's is the most expensive disease in the United States with costs reaching \$277 billion a year and affecting 5.7 million Americans (Alzheimer's Impact Movement [AIM], 2018). With emerging technologies and advancements in medicine, the aging population is living longer, and these costs are estimated to rise dramatically. It is estimated that by 2050, 14 million Americans will have Alzheimer's disease [AD] (Alzheimer's Association [AA], 2018). This burdensome disease not only affects the individual, but also those who are responsible for their care, which is often family members or close friends (AA, 2018; Adelman, Tmanova, Delgado, Dion, & Lachs, 2014; AIM, 2018). Approximately, 16.1 million family members and friends bestowed 18.4 billion hours of uncompensated care to individuals with Alzheimer's disease and related dementias (ARD) in 2017; that has an economic value of more than \$232 billion (AIM, 2018). Caregivers serve an integral role in the support and care of individuals affected with ARD and the need to support them is essential, so they can remain the frontline providers of

care.

To reduce health disparities among this population, efforts to close detrimental gaps in care within the healthcare system are needed. (4) The Alzheimer's Association Dementia Care Practice Recommendations (AA DCPR) are newly developed recommendations addressing all aspects of care to provide quality, patient-centered care across all practice settings (Fazio, Pace, Maslow, Zimmerman, & Kallmyer, 2018). The recommendations support evidence-based findings that the quality of care rendered to individuals and caregivers of ADRD is contingent upon clinicians' methods to accurately assess and care plan (Molony, Kolanowski, Van Haitsma, & Rooney, 2018).

10

Although nothing can change the underlying course of disease in ADRD, interventions can be implemented to benefit patients and their caregivers; care planning has proven to be the most important aspect of care in this population, because it is personalized and specific to their needs (Alzheimer's Association Expert Taskforce, 2016). ADRD is extremely complex, and the delivery of care cannot be approached as a one-size-fits-all method. Patients and caregivers need personalized, individual attention, and thorough assessments and care planning will help facilitate quality care by connecting patients and caregivers to needed services, and recognizing areas needing attention (Alzheimer's Association Expert Taskforce, 2016).

Statement of the Problem

ADRD is a complex, and debilitating neurogenerative disease. Currently, over 5 million adults have ADRD, and of those affected, 81% are ages 75 and older (AA, 2018). It is the sixth leading cause of death in the United States and its numbers are exponentially growing (AA, 2018). Processes aimed to improve the care of patients afflicted with ADRD were lacking, and interventions to assess the needs and enhance the quality of life in these patients were needed. Comprehensive assessments and care planning are vital components in addressing the multifactorial aspects of dementia care. Including caregivers in all aspects of care, reinforces the fact that they are integral members of the treatment team, and to the health of the patient. Including them helps address any deficits in their knowledge, lack of support, barriers to receiving care, and reduces any stress or burden felt by taking care of the patient (Alzheimer's Association Expert Taskforce, 2016; Physician Consortium for Performance Improvement [PCPI], 2011). To address the problem statement, the clinical question was created: Can

integrating an evidence-based care planning toolkit in an outpatient mental health clinic enhance care by effectively addressing the needs of patients with ADRD and of their caregivers?

11

Background and Significance

Dementia is broad term characterized by an insidious and continual deterioration of cognitive functioning in one or more domains of memory, executive functioning, language, judgement, and spatial abilities, which impairs activities of daily living (ADL) and is not related to the normal process of aging (PCPI, 2011; U.S. ⁵ Department of Health and Human Services, National Institutes of Health, National Institute on Aging [HHS, NIH, NIA], 2017). There are several different types of dementias and pathologies. ⁶ Alzheimer's disease (AD), vascular dementia, dementia with Lewy bodies, frontotemporal lobar degradation, Parkinson's disease, Creutzfeldt Jakob disease, mixed dementias, and normal pressure hydrocephalus (AA, 2018; Maloney & Lahiri, 2016).

Recent studies conducted at autopsy reported that many people have mixed dementia,

which is characterized by more than one type of dementia, and it is often AD and vascular dementia combined (AA, 2018). Vascular dementia occurs from the brain being deprived of oxygen due to an infarct from cardiovascular disease (AA, 2018). AD accounts for up to 80% of all dementias and is the most common and progressive type (AA, 2018). Neuropathologically, AD is characterized by the aggregation of parenchymal plaques primarily consisting of amyloid β peptide ($A\beta$) protein, and neurofibrillary tangles of protein tau, which leads to the degradation of neurons (Maloney & Lahiri, 2016).

Symptoms of each dementia type vary among each disease and the individual affected.

Some dementias progress rapidly like AD and Lewy bodies dementia, and others are insidious, and individuals remain in the mild to moderate stages of symptoms for longer periods of time (AA, 2018; Maloney & Lahiri, 2016). In the mild states of ADRD, neuronal changes have

12

occurred, and minimal assistance may be needed to ensure safety, but individuals are capable of functioning independently (AA,2018).

Most people linger in the moderate stage of ADRD the longest (AA, 2018). In this stage, people start experiencing difficulty performing routine tasks, communicating effectively, personality and behavior changes occur, and neuropsychiatric symptoms (NPS) begin to emerge; NPS has been identified throughout the literature as an important variable affecting caregiver burden and stress (American Academy of Neurology, American Psychiatric Association [AAN & APA], 2016; Terum et al., 2017; ⑦ The Workgroup on Alzheimer's Disease and Other Dementias [WG ADOD], 2010).

Lastly, it is in the severe stage of ADRD when neuronal degradation to areas of the brain controlling movement have occurred, the physical health of the person becomes poor (AA, 2018). It is during this time that individuals affected by ADRD require total care. They become bed-bound, and have difficulty swallowing, which leaves them susceptible to infections, and other conditions; aspiration pneumonia is a result of impaired swallowing and is a leading cause of death in the severe stages of ADRD (AA, 2018).

The global prevalence of all dementias is approximately 35 million, and by 2050, it will exceed to over 100 million people. (Maloney & Lahiri, 2016). The cognitive deterioration experienced with ADRD is a significant burden on the individual affected, the economy, healthcare system, and their caregivers. Caring for persons with ADRD can be a challenging task because they require individualized assistance, attention, and eventually, around-the-clock care. Family caregivers often feel inadequately prepared to effectively manage the multifarious needs of this special population. They are often tossed into the caregiving role without receiving any specialized training, education on disease management, support from the healthcare system, or

13

the community, which can leave them prone to experiencing physical, mental, and psychosocial adverse health effects (Adelman, et al., 2014). Furthermore, the lack of support, resources and education to the caregivers, exposes the patient to receiving substandard care, and increases their risk of abuse and neglect (WG ADOD, 2010). The value of ADRD caregivers is insurmountable to the economy; the care they provide exceeds the value that would be spent on home health or nursing home costs (Adelman et al., 2014). Ensuring that their needs are met is vital in maintaining optimal health in the patient.

Assessment

Microsystem Assessment

The site of the evidence-based project that was located within a medical center complex in the southern United States. It is a large, independent, outpatient psychiatric-mental health clinic that is not affiliated with any healthcare systems. The clinic has been in operation for less than three years and has experienced a rapid growth. Due to the dire need of mental health services in this area, three other clinics have been opened throughout the state in different cities within this short time frame. The clinic has several departments dedicated to integrating cutting edge technologies by taking a patient-centered approach to improve mental health solutions with medication management, psychotherapy, ketamine infusion therapies, transcranial magnetic stimulation (TMS), and telepsychiatry services.

The clinic has 35 employees total. There are two psychiatrists, and five prescribers that see patients after initially being assessed by a psychiatrist. There are eight psychotherapists trained in a variety of therapeutic modalities, and patient populations, to effectively treat disorders and develop healthier coping strategies. Many of the staff members are fluent in Spanish, which attracts a large Spanish speaking population to this specific clinic. On average, 14

the clinic sees approximately 550 patients a week. The clinic serves a diverse population, accepts patients of all ages and most insurances, to promote health across the lifespan.

All new patients are scheduled for an initial evaluation and electroencephalogram (EEG)

before the first visit with any clinician (prescriber or therapist). This aligns with the mission of the clinic in providing cutting edge innovative technologies. A thorough psychosocial evaluation is also completed by an LPC at this time, and all patients are given several self-evaluative assessments to complete which include:

- Screening, Brief Intervention and Referral to Treatment (SBRIT) to identify patients who use drugs or alcohol at risky levels;
- Alcohol Use Disorders Identification Test (Audit) identifies hazardous drinkers or those with an active alcohol disorder;
- Drug Abuse Screening Test (DAST) assesses drug abuse including prescription drugs;
- Hooked on Nicotine Checklist (HONC) measures the dependence on nicotine products;
- Bipolar Inventory of Symptoms Scale (BISS) which assesses for mania, depression,

- Bipolar Inventory of Symptoms Scale (BIS) which assesses for mania, depression, anxiety, irritability, and psychosis, which are symptoms observed in bipolar disorder.

- Think-it is a computerized assessment tool utilized to detect cognitive dysfunction in people with major depression.

These screening instruments are designed to aid clinicians in appropriate questioning and evaluation methods to make an accurate diagnosis. In addition to the screening instruments which are given to every patient at check-in, each clinician employs additional screeners which are used at their discretion depending on the presentation of each patient.

15

Needs Assessment

The microsystem assessment conducted in the fall of 2018 indicated that the clinic lacks a standardized method in assessing and managing the needs of patients with ADRD.

Approximately 8% of patients in this clinic have an established diagnosis of some type of dementia; 66% are female, 34% are male. The largest age group affected with ADRD are ages 75-85 years old at 34%, the second largest is ages 65 and younger at 28%. Ages 65-74 were affected at 26%, and ages over 85 are at 12%. Medicare, Tricare and United Health are the three most common insurances carried among this population. Half of these patients were referred to this clinic for the management of neuropsychiatric symptoms (NPS) from their primary care providers.

Although clinicians addressed many of the domains necessary for providing patient-centered quality care, the system is not uniform, and several of the required elements from the practice recommendations were not fully addressed due to time constraints. The AA DCPR states that a comprehensive person-centered assessment should be completed at baseline, and interim reassessments should be conducted regularly, at the minimum of every six months (Molony et al., 2018). All comprehensive assessments should include the following domains:

- Cognition
- Function
- ⑧ • Stage of cognitive impairment
- Decision-making
- NPS including depression
- ① • Medication review and reconciliation

- Safety and risk reduction

16

- ① • Caregiver identification and needs assessment

- Advanced care planning

A chart audit was performed on 60 patients with an established diagnosis of at least one type of dementia or mild cognitive impairment who were seen in the clinic between 06/01/2018-11/01/2018. Of those patients, 0% had documentation of all 10 of the required assessment domains addressed during their visits, or partial components of each domain addressed. It is evident that the practice recommendations from the AA are underutilized, and this clinic would benefit from a quality improvement evidence-based project aimed at effectively implementing them. ① The Alzheimer's Association Expert Task Force (2017) has published a care planning toolkit which aligns with the practice recommendations of the AA DCRP designed to provide guidance on the diagnosis and management of ADRD patients.

During appointments, prescribers divided their time between conducting brief psychoeducation to both caregivers and patients, and the decision-making process for the management of NPS. The psychoeducation and list of community referrals given during appointments is beneficial but limited. Although caregivers reported frustration or areas of concern in managing NPS at home, no specific interventions were documented in the electronic medical record (EMR) addressing if caregivers were assessed for burden/stress, depression, referred to supportive services, or if a needs assessment was conducted. The only interventions documented were patient referrals for psychotherapy if depression or anxiety was noted or suspected. Utilizing a toolkit could enhance the current measures already established in this clinic by helping patients live the best life they have left by addressing their needs. It facilitates a uniform, systematic approach for all clinicians to provide active, meaningful care, and will help

17

address the unmet challenging needs of this population (Alzheimer's Association Expert Taskforce, 2016; Molony et al., 2018).

Organization's Readiness for Change

All major stakeholders of the outpatient psychiatric-mental health clinic expressed an interest and engagement to participate in an evidence-based quality improvement project for the care of patients with ADRD.

Since the clinic is currently in the process of seeking accreditation with the Joint Commission, the major stakeholders are vested in developing standardized procedures and protocols which parallel with current clinical guidelines. All prescribers were knowledgeable of previous practice recommendations and quality measures set by various organizations, but not all were aware of the AA DCPR since they are newly adopted recommendations. Those who lacked knowledge were made aware of the new practice recommendations and were briefed on the changes. All interviewed prescribers felt they addressed every domain of care per the AA DCPR; however, it was not evident in the documentation. Integrating a toolkit can help assure that all domains have been assessed because

① it requires a written care plan (Alzheimer's Association Expert Task Force, 2017).

Major stakeholders and providers were unaware that Medicare now reimburses for ADRD assessment, care planning and coordinating services with a new current procedural terminology (CPT) code 99483 (Alzheimer's Association Expert Task Force, 2016). CPT code 99483 offers a significantly higher reimbursement rate, than other CPT codes which are often used for addressing many of the same components of care. Clinicians are eligible for Medicare reimbursement of \$242.85 every six months for comprehensively assessing patients with ADRD with this toolkit (Alzheimer's Association Expert Task Force, 2017), so it is anticipated that introducing CPT code 99483 will bring more revenue into the clinic. Upon reviewing the

18

requirements for reimbursement and educating all clinicians on the differences, all parties committed to supporting the integration of this toolkit to help facilitate the delivery of care. The practice manager and lead nurse also participated in facilitating this new process and verbalized the importance of communicating effectively with all parties to ensure its success.

Although the organization's stakeholders expressed a willingness for improvement, there were barriers associated with implementing a project at this site, such as the underutilization of the EMR's capabilities.

Project Identification

Purpose

The purpose of this project was to implement the AA Cognitive Impairment Care

Planning Toolkit (2017) to create a systematic algorithm within the clinic to aid clinicians in conducting a person-centered comprehensive assessment and care plan for patients with ADRD.

Objectives

The objectives of this evidence-based quality improvement project were to:

1. Increase the number of patients with ADRD and their caregivers screened using the validated, standardized assessment tools found within the toolkit by 75% in eight weeks.
2. Increase the number of patients and/or caregivers who were identified as having unmet need(s) that received appropriate follow-up or referrals by 75% in eight weeks.
3. Increase the number of written care plans formulated from the comprehensive assessment by 75% in eight weeks.
4. Increase revenue by utilizing billing CPT code 99483 for every patient who was assessed with the toolkit within the eight weeks.

19

By meeting the above objectives, clinicians are aligned with the most current practice recommendations for the management of ADRD and will provide high-quality, patient centered care (Fazio et al., 2018).

Summary and Strength of the Evidence

No empirical studies were found which used the AA Cognitive Impairment Care Planning Toolkit (2017), however, other models, current practice guidelines, performance measure sets, and systematic reviews related to cognitive impairment and ADRD were reviewed. Most models of care are limited to a specific setting, domain, or discipline. For example, the Age-friendly Primary Health Care Centres Toolkit from the World Health Organization [WHO], (2008) assesses for many age-related health concerns, and should only be used in the primary medical-care setting. The Kickstart-Assess-Evaluate-Refer [KAER] Model was designed for early detection and assessment of cognitive impairment, diagnosing, and referring out to community resources, but does not address any other domains (GSAWG, 2017; Maslow & Fortinsky, 2018). Caregivers Count Too! is another domain specific toolkit which intervenes through supporting, encouraging, and educating caregivers by conducting an in-depth caregiver needs assessment to promote health (Family Caregiver Alliance, 2006).

The Physician Consortium for Performance Improvement (PCPI) published a set of

quality measures designed to improve health outcomes of people with ADRD and of their caregivers (2011). These quality measures can be used in any outpatient setting and imparts the importance of conducting a comprehensive assessment regularly. (9) The U.S. (5) Department of Health and Human Services ASPE conducted a detailed analysis of models of dementia care by reviewing 37 existing clinical guidelines. From this, they established several imperative care 20 components that should be addressed regularly by multidisciplinary clinicians as a standard of care (Wiener, Gould, Shuman, Kaur, & Ignaczak, 2016).

Although no collective studies were acquired using a specific toolkit, or performance measures, there is significant evidence throughout the literature expressing the importance of (1) assessing each domain contained in the AA Cognitive Impairment Care Planning Toolkit individually. Utilizing validated and reliable instruments has proven to be effective in assessing, measuring, and detecting changes in each domain, and should be incorporated into treatment planning services for patients with ADRD (Cunningham, Cunningham, & Roberston, 2018; Molony et al., 2018). Findings within the literature review are summarized by each domain below.

Cognition

Cognitive impairment (CI) among the elderly in the United States remains under detected (GSA WG, 2017), thus, conducting regular cognitive evaluations should be performed. Patients with established CI, or ADRD, should be assessed every six months at minimum, to track changes and disease progression (AAN & APA, 2016; Fazio et al., 2018; GSA WG, 2017; PCPI, 2011). Because certain types of dementias evoke a more rapid progression in symptomology, performing regular cognitive evaluations with reliable and valid instruments will aid clinicians in detecting new symptoms earlier, generating individualized treatment plans tailored to current needs, and offering supportive and educational services earlier to maintain quality of life and maintain independence (AAN & APA, 2016; GSA WG, 2017; WG ADOD, 2010).

(10) The Saint Louis University Mental Status examination (SLUMS) is one of many valid and reliable instruments that assesses for the presence of cognitive deficits and its changes over

⑦ time (Feliciano et al., 2013). It can be administered in less than 10 minutes by any qualified

21

healthcare professional who has been trained, and it screens several cognitive domains such as, attention, calculation, immediate and delayed recall, animal naming, abstract thinking, and visuospatial skills (Feliciano et al., 2013; Howland, Tatsouka, Smyth, & Sajatovic, 2016). In a cross-sectional design of (n=170) nonveteran community dwelling adults between the ages of 60-91, by Feliciano et al. (2013), the SLUMS was compared to the Mini-Mental Status Examination (MMSE) to predict its validity in memory and executive functioning. Results suggested that the SLUMS is an effective tool and is stronger than the MMSE in assessing for memory and executive function (Feliciano et al., 2013). Memory and executive functioning in older adults are extremely important to assess regularly because these areas often decline first.

Function

Dementia is a progressive disease associated with the loss of independence in functional status, so supportive care with ADLs will eventually be required (Prizer & Zimmerman, 2017). This loss of independence correlates with a poorer health status and quality of life (Prizer & Zimmerman, 2017), therefore, assessing function regularly is vital. Assessing function in patients with ADRD or suspected MCI can be achieved by utilizing valid and reliable instruments. Screening for basic ADLs includes the patient's ability to independently feed, dress, and bathe, while instrumental (IADLs) concentrates on more advanced self-care activities like shopping, cooking meals, proper medication administration, and managing financial matters (PCPI, 2011). Establishing the capacity for self-care and independent living is beneficial for advanced care planning because it allows clinicians to initiate hard to discuss topics such as when to stop driving, and when institutionalization may be necessary, with patients and families early-on in the disease process (Molony et al., 2018; PCPI, 2011). It is also beneficial for planning

22

interventions that help promote independence, respect, dignity, and choice for the person losing their functional abilities (Prizer & Zimmerman, 2017).

The AA, KAER, and PCPI recognizes the Katz index of Independence in ADL and the Lawton-Brody IADL as valid and reliable screening instruments for assessing functional status

① in the geriatric population (Alzheimer's Association Expert Task Force, 2017; GSAWG, 2017;

PCPI, 2011). Both Katz and Lawton-Brody scales are best used for detecting problems in

performing ADLs independently among the elderly across a variety of care settings. They provide data in identifying individualized needs for specific services that may be needed in the home and are sensitive to big changes in health status (Alzheimer's Association Expert Task Force, 2017).

Stage of Cognitive Impairment and Decision-Making Capacity

The staging of dementia is not frequently addressed, yet it is an important component of evaluation; it helps differentiate normal aging from MCI, and between MCI from AD (Moelter et al., 2016). A 3-level rating scale is used to rate the decisional-making capacity and it is derived from clinical judgement. Mild dementia indicates some difficulty in completing tasks such as balancing a checkbook, preparing multi-step meals, or adhering to a complex medication regimen, but the person is still able to remain independent in many areas of their life (AA, 2018;

PCPI, 2011). In the moderate stage, patients will experience difficulty with more simpler tasks such as minor household and yard duties, preparing a simple meal, or requiring assistance in some or all aspects of care (AA, 2018; PCPI, 2011). They may start wandering, become confused, and develop NPS (AA, 2018). In the severe stages, patients will require total assistance in all personal aspects of ADLs, and IADLs (AA, 2018; PCPI, 2011).

23

② The Dementia Severity Rating Scale (DSRS) is valid and reliable tool that effectively gauges level of impairment and detects slight changes of function over time (Moelter et al., 2015). The tool takes less than five minutes to complete and is easy to administer. Results from Moelter et al. (2015), indicate utilizing the DSRS along with cognitive testing enhanced diagnostic accuracy, and a score change of ≥ 10 from previous scores was excellent in differentiating the progression from MCI to AD.

Neuropsychiatric Symptoms (NPS)

NPS results from neurodegeneration of the diseased brain in ADRD and occurs in up to 97% of people (Scales, Zimmerman & Miller, 2018). Symptoms include, agitation, apathy, motor disturbances, anxiety, irritability, depression, disinhibition, delusions, hallucinations, nighttime behaviors, euphoria, and appetite changes (Scales et al., 2018); it accelerates cognitive

decline, functional impairment, increases co-morbidities and hospitalizations, decreases mean survival time, and increases risk of danger to self and others (AAN & APA, 2016). NPS has been identified throughout the literature as the most poignant sequelae of ADRD (Scales et al., 2018), and as one of the leading factors attributing to caregiver burden (Adelman et al., 2014; Terum et al., 2017). Due to the potentially dangerous consequences NPS poses, patients should be assessed regularly to manage all negative symptoms, and modifiable interventions to the social and physical environment should be implemented (AAN & APA, 2016; Scales et al., 2018; WG ADOD, 2010).

① The Neuropsychiatric Inventory Questionnaire (NPI-Q) is a quick, valid and reliable caregiver rated screening tool that can be routinely administered in any clinical setting (Musa, et al., 2017). It is used to measure the presence or absence of 12 symptoms of NPS in ADRD and allows the caregiver to gauge the severity of distress of each symptom (Musa et al., 2017). In 24

order to establish the NPI-Q psychometric properties, and the prevalence of NPS in patients with AD, Musa et al. (2017), studied 53 patients with diagnosed AD. Results indicated a correlation between the progression of AD and an increased prevalence of NPS; symptoms with the highest prevalence were delusions (44.2%), agitation/aggression (36.7%), and aberrant motor behavior (28.9%). The NPS assessment is relevant for the differential diagnosis in ADRD as well as assessing behavioral responses to pharmacological and non-pharmacological interventions (Musa et al., 2017).

Depression

Depression is the most common NPS in dementia, affecting over 50% of patients (PCPI, 2011). Even mild cases of depression can significantly impact those with ADRD and is linked with higher rates of disability, mortality, and poorer quality of life (PCPI, 2011). Furthermore, as the severity of depression increases, the severity of psychopathological and neurological impairments increases (PCPI, 2011). Identifying depression in this population is essential and can be differentiated between other symptoms of NPS by validated assessment instruments.

The Patient Health Questionnaire-9 (PHQ-9) is a reliable instrument utilized for screening depressive disorders based off symptomology from the Diagnostic and Statistical Manual of Mental Disorders (DSM, Fifth Edition) (Moriarty, Gilbody, McMillan, & Manea, 2015; PCPI, 2011). It is widely used in a variety of clinical settings. ⑪ In a meta-analysis by

Moriarty et al. (2015) at cutoff point 10, the PHQ-9 showed a higher sensitivity and similar specificity in primary care when compared to community and secondary care settings. The PHQ-9 is effective in differentiating between major depressive disorders and other mood disorders when coupled with clinician evaluation (Moriarty et al., 2015). The literature lacked evidence on its validity and reliability in the CI geriatric population.

25

① Medication Review and Reconciliation

Conducting a careful review of medications and reconciliation on a regular basis is endorsed within the literature. Medications often contribute to impaired cognitive dysfunction and clinicians should be aware of all medications, especially high-alert and inappropriate medications to minimize risk of adverse drug events which could result in worsening cognition, or safety (Molony et al., 2018). Assessing for medication adherence in the reconciliation process is paramount after a list is obtained. This tells clinicians if pharmacologic interventions were effective in minimizing or worsening symptoms and its tolerability. In many cases, the inability to manage medications appropriately is the only sign of functional impairment, and this

differentiates MCI from a dementia diagnosis (Hudani & Rojas-Fernandez, 2016). This population presents with a set of unique circumstances in achieving or maintaining optimal medication adherence. Circumstances include complex medication regimens, polypharmacy, health care system barriers, declining health status, increased co-morbidities, and socioeconomic barriers (Hudani & Rojas-Fernandez, 2016). In addition, the ability to effectively adhere to medications entails working memory, verbal memory, processing speed, and reasoning skills that people with ADRD lack (Hudani & Rojas-Fernandez, 2016). Because of this, caregivers generally take the responsibility of managing medications among this patient population, and self-reports (32%) are the most commonly used method in obtaining a medication list and assessing for adherence, second to pharmacy data (27%), pill count (14%), health provider report (14%), electronic monitoring (10%), and clinical health outcomes (3%) (Hudani & Rojas-Fernandez, 2016). The literature lacks evidence on the best method in obtaining an accurate medication list, so individualized care can be achieved.

26

Safety

Living home alone without supervision poses many challenges for those with ADRD. As the level of CI progresses, functional abilities decline, and safety issues arise (Molony et al., 2018). Evaluating and planning for environmental safety hazards reduction is one of the most valuable types of support clinicians can contribute to this population and should be conducted periodically with both patient and caregiver (Calkins, 2018; Molony et al., 2018). By implementing interventions that support a therapeutic and supportive environment, patients can maintain their dignity and comfort which positively impacts their quality of life, independence, and length of time before institutionalization (Calkins, 2018; Molony et al., 2018).

There is no single valid and reliable screening instrument that assesses for safety in CI

① adults, however, the Cognitive Impairment Care Planning Toolkit (2017) contains a safety assessment guide to aid clinical questioning over seven key areas concerning environment; driving status, medication management, home hazards, access to firearms, fall risk, wandering or getting lost, and living status. These topics are also consistent with the recommendations from the PCPI (2011), and the systematic review of existing models of dementia care conducted by Wiener et al., (2016). Weiner et al., (2016) and PCPI (2011) both address safety concerns of abuse and neglect suffered to the patient, whereas the AA's toolkit lacks direct questioning over that specific topic.

① Caregiver Identification and Needs Assessment

Caregivers of persons with ADRD are susceptible to increased risks of depression, anxiety, burden, stress, and are associated with increased risk of mortality themselves (Adelman ⑦ et al., 2014; Odenheimer et al., 2013; Terum et al., 2017). Up to 40% have symptoms of depression or anxiety (Livingston et al., 2014). ⑩ In a systematic review of previously published literature reviews (n= 19) of caregiver wellbeing, Cunningham et al. (2018), found that burden

27

(10) and depression (8) were characterized as the top terms in describing caregiver wellbeing throughout the literature. Their review also concluded that current research lacks a standardized method and robust screening approach to incorporate both positive and negative aspects of providing care to determine burden. The PHQ-9 has proven to be a highly valid assessment tool in screening for depression as described earlier. ① My Stress Thermometer is a quick and easy

method to rate stress levels. It can be done in a matter of seconds by marking current stress level on the body of a thermometer; rating ranges from "not stressed at all", "a little stressed", "moderately stressed", "very stressed", and "extremely stressed" (Alzheimer's Association Expert Task Force, 2017).

Conducting a multicomponent needs assessment for caregivers will help to better understand their individualized needs and assist with improved care planning efforts (Whitlatch & Orsulic-Jeras, 2018). The Cognitive Impairment Care Planning Toolkit contains a caregiver profile assessment to appraise caregiver knowledge over various topics such as: understanding of ADRD, where to obtain sources for additional information, where to receive supportive services, and willingness to provide care (Alzheimer's Association Expert Task Force, 2017). This profile is consistent with findings in the literature supporting the need for greater caregiver support, education, and information across all stages of dementia to improve quality of life, and mental health outcomes in both patient and caregiver (PCPI, 2011; Schoenmakers, Buntinx, & DeLepeleire, 2010; Whitlatch & Orsulic-Jeras, 2018). Furthermore, evidence also shows that the health status of individuals affected with ADRD is significantly dependent on the care they receive at home (Terum et al., 2017). Therefore, providing education, information, appropriate referrals, screening for depression, and stress are all critically important pieces for reducing

28

adverse effects associated with caregiving, and should not be overlooked during the comprehensive assessment (PCPI, 2011; Terum et al., 2017; Whitlatch & Orsulic-Jeras, 2018).

Advanced Care Planning

Advanced care planning (ACP) facilitates planning for future care in patients with chronic illness, so when they are unable to make financial and medical decisions on their own, their wishes can be carried out (Robinson et al., 2010). Since ADRD follows a gradual declining course, the literature supports early efforts for clinicians to initiating conversations to discuss advanced directives before capacity is lost. ACP counseling is recommended to be completed within two years of diagnosis with documentation of advanced directives in the medical record, however, it is rarely done (AAN & APA, 2016; Robinson et al., 2010). Having the patient

participate in ACP maximizes autonomy and honors individual preferences for future care

(Molony et al., 2018).

ACP should incorporate essential components such as decision-making power, planning symptom management, comfort care, and end of life care (Alzheimer's Association Expert Task Force, 2017; Molony et al., 2018; ⑥ Robinson et al., 2010). Assessing for knowledge and attitudes towards end-of-life care in both the patients and family can guide clinicians in effective intervention strategies (Molony et al., 2018). Historically, dementia patients are less likely than those with cancer to complete AD (Robinson et al., 2010), so this population may require additional services/referrals, such as with a social worker for ongoing counseling and education of ACP (Molony et al., 2018).

Overall, the literature reflected improving health care delivery systems among the ADRD population as a challenging task. Due to the complexity of the disease itself, and the many psychosocial factors which influence patients and their caregivers, approaching this

29

collaboratively with a multidisciplinary team would be useful in reducing disparities in dementia care. There was evidence to support the benefits of implementing a multidimensional

① assessment protocol such as the AA Cognitive Impairment Care Planning Toolkit in a mental health clinic. All evidence reflected the importance of regular assessment and frequent reassessment in key domains of cognition, function, NPS, medication review, caregiver needs, and advanced care planning. Evidence was also consistent with supporting the utilization of validated screening instruments in assessment methods. Tracking disease progression and planning interventions can enhance quality of life and equip caregivers with the essential resources to provide the best care possible during this challenging time.

Methods

The project had five major implementation phases: 1). Developing an efficient process to screen, assess, and appropriately bill identified patients 2). Obtaining approval by the organization's leadership 3). Training necessary staff on the new process 4). Implementing the new process 5). Evaluating the implementation and outcomes. Each step will be discussed below in detail.

Project Intervention

Step 1: Developing an efficient process to screen, assess, and appropriately bill. Prior

to implementation, a template within the EMR program was created to document assessment results into the patients EMR titled "Comprehensive Cognitive Impairment Assessment (CCIA)". Utilizing this template ensures uniformity in documentation, tracking disease progression and associated symptoms over time, and guide clinicians in establishing a personalized care plan for ADRD patients and their caregivers.

30

The universal order sheet utilized by all staff within the office was updated. A selection box for the CCIA was added to the order. In addition, a new appointment type was created into the electronic scheduling system, which allowed the selection of the new CCIA appointment type to be made. All CCIA appointments scheduled were set for 1.15-hours in duration under "psychotherapy services" and automatically coded with billing CPT 99483.

Step 2: Obtaining approval by the organization's leadership. Due to the magnitude and implications of this project, it was decided that this would run as a pilot project for the course of eight weeks. Only one bilingual prescriber would participate in identifying and referring patients to be assessed with the CCIA toolkit, and one bilingual therapist would be trained on how to conduct the assessments. This allowed time to examine its feasibility within the clinic and allowed for adjustments, before implementing it throughout the organization. Key stakeholders also decided to best serve the clinic's patient demographics, only validated screening instruments available in both English and Spanish should be utilized. Several ^① screening instruments recommended by the AA Cognitive Impairment Care Planning Toolkit were replaced with other valid instruments, and all checklists were translated into Spanish to ensure all clients and their caregivers received the same checklist (see appendices B-N).

After making modifications based on key stakeholders' recommendations, organizational

approval to implement the project was obtained by all owners of the outpatient clinic. A letter of support was written from one of the owners and is listed in Appendix A. The proposed plan was submitted to the University of the Incarnate Word Institutional Review Board (IRB), and was determined to be a quality improvement project therefore, exempt from IRB approval.

Step 3: Training necessary staff on the new process. Several copies of the CCIA

toolkit were printed and used for training purposes. The selected prescriber and therapist

31

received an individual training session over each standardized scale within the toolkit, scoring instructions, and overview of the new CCIA template for documenting results. Each were given a copy of the CCIA toolkit to reference for future use (see table 1). Lastly, all staff received education on the different roles and responsibilities of each member prior to implementation.

Table 1 Summary of Toolkit Contents

Person responsible for completing

Domain

Measure

Available in Spanish

Patient/caregiver Med list & reconciliation Medication list Yes

Caregiver Rating patient

Staging

DSRS

No

Function KATZ Yes Function Lawton-Brody Yes NPS NPI-Q Yes Caregiver Rating self

① Caregiver needs assessment

My Stress Thermometer

No

Caregiver needs assessment PHQ-9 Yes Caregiver needs assessment Caregiver profile Yes Clinician Cognition SLUMS Yes Depression PHQ-9 Yes Safety Safety assessment checklist Yes ACP End-of-life checklist Yes Decision making capacity Capacity Assessment No

Step 4: Implementing the new process. Beginning on day one of implementation, all

patients having a diagnosis of AD/DRD, MCI, or a strong suspicion of CI, who was seen by the

selected prescriber had orders written to receive the CCIA toolkit. An electronic list of all

identified patients was compiled in a secured Microsoft TEAMS account which enabled DNP

student, prescriber, and therapist to communicate. All identified patients were scheduled with a

CCIA appointment with their caregiver, prior to leaving the office. Since this was a new process

within the organization requiring an adjustment period, all patients scheduled for a CCIA

appointments were flagged with electronic reminder notes to pop-up at check-in. This prompted

the therapist conducting the assessment to ensure the correct appointment type was scheduled to

allow for adequate time to conduct the assessment (1.15 hours) and ensure for correct billing.

32

After checking in on appointment day, the therapist escorted the client and their caregiver to a private room and read the instructions of each screener to be completed by the caregiver, ensuring literacy and understanding before taking the portion of the toolkit labeled "clinician" out of the folder. The folder contained 4 tabs labeled "patient", "caregiver (rate the patient)", "caregiver (rate self)", and "clinician" (see table 1).

The therapist conducted their portion of the toolkit with the patient as the caregiver filled out their sections simultaneously. After the clinician's portion was completed, the therapist addressed any areas left blank or needing clarification from the caregiver's sections. Thereafter dismissing the client and caregiver, results were entered in the patients EMR, sent to the prescriber for viewing, and the treatment plan was initiated. See the algorithm in Figure 1 to view the process.

Step 5: Evaluating the implementation and outcomes. Throughout the course of the project, several hours a week were dedicated to evaluating its progress by chart review. An evaluation plan was designed prior to implementation to help measure each outcome as stated below.

Outcome 1. Increase the number of patients with ADRD and of their caregivers who were screened using the validated, standardized assessment tools found within the toolkit by 75% in eight weeks. An excel sheet was created in Microsoft TEAMS to identify all patients meeting criteria and was compared with written orders for the CCIA. The charts of each identified patient were reviewed to ensure that an appointment was made to receive the CCIA. Charts of identified patients whose appointment date passed, were checked weekly to see if appointment was kept. If so, CCIA toolkit contents was verified for completion. At project completion, the percentage of patients who completed both would be calculated.

33

Figure 1. Comprehensive Cognitive Impairment Assessment (CCIA) Algorithm

Orders for CCIA written by prescriber

Receptionist makes 1.15-hour CCIA appt for

client AND their caregiver before leaving

ffi

Results in EMR with CCIA template; care plan initiated by LPC

results in EHR with CCA template, care plan initiated by etc.

LPC completes CCIA with client & caregiver

LPC ensures correct appointment

type & CPT code billed

Receptionist makes future appt for client

AND their caregiver 180 days from current date

LPC writes order for

repeat CCIA for 180 days

in future

LPC identifies patient &

caregiver needs

Needs cannot be met at clinic, appropriate referrals

& orders written A series of 4-8

educational/supportive sessions will be

scheduled for client

ex 2: safety in the home ex. 1: planning for the

ex 3: caregiver burden

ex. 4: caregiver burden

Prescriber has a strong

suspicion that client may have

MCI or client has a dx of ADRD

Prescriber enters client information into TEAMS under "CCIA Patient List"

CCIA results reviewed at f/u appt with prescriber. Care plan finalized; patient

34

Outcome 2. Increase the number of patients and/or caregivers who were identified as

having unmet need(s) that received appropriate follow-up or referrals by 75% in eight weeks.

After the completion of outcome one, the contents of each folder were analyzed by each domain

individually. Scores of each screener and answers to checklists were evaluated to determine if

any areas needed further intervention such as education, counseling, or referrals, etc. After

project completion, the percentage of people whose CCIA toolkits indicated an unmet need was identified and also addressed with documented proof, were calculated, and compared to those who had unmet needs identified but did not have follow-up sessions or declined further intervention.

Outcome 3. Increase the number of written care plans formulated from the comprehensive assessment by 75% in eight weeks. The completion of outcome one was needed prior to evaluating outcome three. The EMR of patients who were identified to have received the CCIA were reviewed and verified for template utilization in documenting results. The percentage of all patients who had a care plan started would be calculated and compared to those who did not.

Outcome 4. Increase revenue by utilizing billing CPT code 99483 for every patient who was assessed with the toolkit within the eight weeks. The EMR of patients who were verified as having completed the CCIA would be checked to see if the correct appointment type was made on the date of CCIA completion. Since the appointment type was created to be coded automatically with CPT 99483, that ensured correct billing. If any patients had the incorrect appointment type entered, but received the CCIA, then CPT code(s) utilized for that specific appointment date would be logged. The percentage of appointments billed with CPT 99483 were calculated at project completion.

35

Organizational Barriers and Facilitators

Organizational barriers which influenced the outcomes of this project were the high levels of prescriber and therapist practice autonomy, and high employee turnover. During a two-month period, the clinic lost eight employees across several departments. Although new staff were hired, positions, roles, and responsibilities were unclear during this transitional period; many staff felt overwhelmed with the additional responsibilities assigned to them, including the implementation of this project. This caused significant delays in implementation, especially related to scheduling.

Due to significant personnel changes and lack of management oversight over several years, there was minimal interprofessional teamwork within the clinic. Neither departments nor clinicians communicated with one another regularly. Each practiced in silos, resulting in incongruity between professions, and high levels of group autonomy in their daily functions

which are both profound barriers in institutionalizing change (Tataw, 2012). Although clinicians verbalized interest in learning how to administer the CCIA, none attended the scheduled training sessions. Since this project involved multidisciplinary participation, the cultural inertia of the clinic hindered its progress resulting in substantial delays.

According to Tataw (2012), a strong group identity weakens organizational interprofessional collaborative practice. In order to reconstruct clinical practice into synergistic processes and systems, interdisciplinary education and socialization is essential, and has been proven to improve performance, and employee retention (Tataw, 2012). After significant delays in implementation, an additional clinical mentor within the organization was recruited as a facilitator. She was successful in enlisting a therapist to be trained so the project could commence. Throughout the length of the project, she continued to challenge the organizational

36

inertia by motivating and educating clinicians on the many practice implications this project offers and strengthening interdisciplinary collaboration between departments.

Originally, the EMR served as a barrier, however, prior to implementation, the EMR software was updated which allowed for the creation of CCIA template to be built into the system. The update was advantageous because it helped close one of the gaps in care that the organization struggled with overall, which was the underutilization of EMR capabilities.

Ethical Considerations

With the uncertainty of the amount of time associated conducting a comprehensive assessment with demented patients, and the many organizational barriers faced, a consensus was reached among major stakeholders that this would be a pilot project and was limited to one prescriber to identify patients who met criteria, and one therapist to conduct assessments.

Stakeholders verbalized interest in comparing longer term measures (6+ months) to evaluate the

effectiveness of the toolkit before implementing it as a standard of practice within all clinics.

Although not all patients were evaluated with the CCIA contents, or benefited from purposed interventions, they still received the current standard of care this organization employs which meets minimal standards. All clients requiring medical management or services other than

neuropsychiatric symptom management were continued to be referred to their primary care providers.

All data was kept secure and anonymous with the use of an encrypted external hard drive which met HIPAA standards. The Microsoft TEAMS account created to communicate project information between all participating clinicians was within a secured site; only medical record numbers and initials were used. Completed CCIA toolkits were kept in a locked filing cabinet in the therapist's office until its contents could be uploaded into their EMR and then destroyed.

37

Results

During the eight-week implementation phase, 15 patients met criteria to be screened.

Eleven (73%) (n=11) were screened with the CCIA toolkit. The ages of patients ranged from 68 to 90 years old, with a mean age of 78.8 years (SD= 6.92). Of these patients, 8 (73%) were female gender, and 3 (27%) were male. The education level of this sample ranged from 3 (27%) did not graduate high school, 5 (46%) graduated from high school but had no further education, and 3 (27%) pursued higher education. The diagnoses of this sample ranged from 2 (18%) having a suspicion of dementia and given ICD-9 of R41.9- Unspecified symptoms and signs involving cognitive functions and awareness; 6 (55%) given ICD-9 of F02.81 Dementia in other diseases with behavioral disturbances; 1 (9%) given ICD-19 of F01.50 Vascular dementia without behavioral disturbances; and 2 (18%) diagnosed with ICD-9 F02.80 Dementia in other diseases without behavioral disturbances. Five (46%) lived with their caregiver(s), 4 (36%) lived independently, and 2 (18%) lived in an assisted living facility (ALF). See Table 2.

Table 2

Demographic Characteristics of Patients

Characteristic No. (%) of Patients (n= 11)

Gender Male 3 (27%) Female 8 (73%) Age 60-69 1 (9%) 70-79 4 (37%) 80-89 5 (45%) 90-100 1 (9%) Education Less than HS graduate 3 (27%) HS graduate 5 (46%) College 3 (27%) Living status Lives alone 4 (36%) Lives with CG 5 (46%) Lives in ALF 2 (18%) Diagnosis R41.9 2 (18%) F01.50 1 (9%) F02.80 2 (18%) F02.81 6 (55%)

Note. HS= high school; CG= caregiver; ALF= assisted living facility

38

All caregivers of these patients were female (100%) (n= 10). One patient that lived in an ALF had no caregiver except employees of the ALF and was excluded from the sample. Of the caregivers, 7 (70%) were children of the patient, 2 (20%) were their spouse, and 1 (10%) was

another relative. All (100%) caregivers had contact with the patient five or more days of week.

See Table 3.

Table 3

Summary Characteristics of Caregivers

Characteristic No. (%) of CG (n= 10)

Gender Male 0 (0%) Female 10 (100%) Relationship to patient Child 7 (70%) Spouse 2 (20%) Sibling 0 (0%) Other relative 1 (10%) Amount of contact per week >than 1 day per week 0 (0%) 1-2 days per week 0 (0%) 3-4 days per week 0 (0%) 5 or more days per week 10 (100%)

Outcome 1

Increase the number of patients with ADRD and of their caregivers who were screened using the validated, standardized assessment tools found within the toolkit by 75% in eight weeks. Fifteen patients were scheduled with CCIA appointments by the selected prescriber; eleven (73%) were screened with the CCIA toolkit, and four (27%) did not show up, or rescheduled their appointment for a later time which was not within the implementation phase of the pilot project (see Figure 2). One of the two patients who lived at an ALF did not bring a caregiver to his appointment, so the toolkit was not completed in its entirety. This brought the caregiver sample population to 10.

39

Figure 2. Screened Patients

Outcome 2

Increase the number of patients and/or caregivers who were identified as having unmet need(s) that received appropriate follow-up or referrals by 75% in eight weeks. All screened patients and caregivers had several unmet needs, which required addressing (see Table 4). The top needs were patients exhibiting neuropsychiatric symptoms (NPS) 9 (81%); patients exhibiting depression 8 (73%); patients displaying deterioration of health functional status 7 (64%), safety concerns in the home 7 (64%), and caregiver reporting stress at a moderate level or higher 7 (64%). Six of the seven caregivers who reported at least a moderate level of stress on the My Stress Thermometer, or PHQ-9 score of 10 or higher indicating moderate depression, were referred for therapy. Three chose to do therapy at the same clinic; one caregiver was already seeing a therapist on a regular basis, the remaining caregivers declined therapy. All nine patients who were displaying NPS had their medications adjusted by the prescriber at their next appointment, as well as the eight patients who reported depression. Three patients and their caregivers were referred to an Alzheimer's activity center close to their homes.

patients and their caregivers were referred to an Alzheimer's activity center close to their homes

that incorporates many services and support to families. All patients and caregivers were given a

list of community and national resources, and the therapist highlighted and explained the

27%

73%

SCREENED PATIENTS

NOT SCREENED SCREENED

40

resources which he thought would most benefit the patient and caregiver. All patients were given

a referral to their primary care provider to initiate case management services.

Table 4 Identified Needs and Referrals Initiated

Need

No. (%) of Patients (n= 11)

No. (%) of CG (n= 10)

% of Appropriate Referrals Initiated

Neuropsychiatric symptoms 9 (81%) 100% Depression 8 (73%) 100% Deterioration of health function 7 (64%) 100% Safety concerns 7(64%) 100% CG stress 7 (70%) 100% End-of-life planning 6 (60%) 0% Support/Resources 6 (60%) 100% Disease knowledge 5 (50%) 0% Depression 2 (20%) 100%

Note. CG= caregiver

Outcome 3

Increase the number of written care plans formulated from the comprehensive assessment

by 75% in eight weeks. All 11 patients screened with the CCIA toolkit had care plans initiated

with the newly created template, and all were given a copy of their individualized care plan to

reinforce goals set, and current treatment plan.

Outcome 4

Increase revenue by utilizing billing CPT code 99483 for every patient who was assessed

with the toolkit within eight weeks. Although CPT code 99483 was coded into the appointment

type for billing, not all patients qualified for reimbursement with this code. (8) Since 6 (55%)

patients were not primarily insured by Medicare or Tricare, the billing department chose to

utilize CPT code 96132 +96133 for services to those patients, and 5 (45%) patients who were

insured with primary Medicare or Tricare were billed with 99483 for services.

41

Discussion

During the first few weeks of implementation, not all patients who met criteria were identified in a timely manner, which led to missed opportunities to screen. Not until another agency facilitator was added to aid in the project, were patients identified and given appointments to be screened. Due to the high practice autonomy, lack of multidisciplinary collaboration, and time limit on this project, the implementation phase was reduced to eight weeks, and limited to one prescriber and one therapist. Patients who were initially missed were called and asked for an appointment date to be screened. Although 26% (4) patients missed or rescheduled their appointments, this turnout is synonymous with all patient populations in the clinic. Several patients felt uneasy being tested for cognitive impairment because they did not want a confirmation of dementia and were scared that their independence may have been taken away. The literature states clinicians should disclose any diagnosis of dementia or cognitive impairment (AAN & APA, 2016); however, this was difficult to accomplish with certain patients and deemed detrimental to their care.

The NPI-Q¹ was originally set for the clinician to conduct with the caregiver, however, this led to arguments between the patient and caregiver. It was then placed under the caregiver's tab, so the caregiver could rate the patient silently. After revising the placement of the NPI-Q¹ screening instrument, there were no more arguments during the appointments, and the assessment was completed without incident. The prescriber also utilized the NPI-Q¹ during the patient's medication management appointment to assess for severity of symptoms. Since NPS is known to be the most distressing ramification of ADRD, and is the leading factor to caregiver burden, patients should be screened regularly to manage the negative symptoms to help reduce

42

poor health outcomes in both patients and caregivers (Adelman et al., 2014; Scales et al., 2018; Terum et al., 2017).

The results of this pilot project were consistent with the literature, in that ADRD is extremely complex to manage due to the many needs of both patients and caregivers. Patients and caregivers need personalized, individual attention of their needs, and should be connected to services to promote health and independence for as long as possible (Alzheimer's Association

Expert Taskforce, 2016).

Limitations

This project had several limitations, beginning with time constraints. Due to the allotted time within the agency, the implementation phase was only eight weeks. This limited the number of participants who were screened, and restricted measurement of its impact on enhancing patient care. The time constraints further limited the ability to review how much revenue the proposed billing code actually brought in since reimbursement often takes several months after billing for services. Therefore, only projected reimbursement rates could be measured for this pilot project. Another limitation was the amount of autonomy all clinicians possessed in patient management. The leadership structure within the agency only recommends for prescribers and therapists to follow new protocols, but does not require their participation. So buy-in was difficult; however, as the project progressed, several prescribers and therapists expressed interests in becoming familiar with the CCIA, which added in future sustainability.

Recommendations

The most recognized and detrimental gap in care within current healthcare systems among this population, is the lack of care planning services (Alzheimer's Association Expert Taskforce, 2016). Failure to recognize the needs of these patients and initiate referrals or services
43
for community resources, such as support groups, adult day programs, and education on ADRD, will only continue to add to the global burden of this disease. Building an educational program for patients, caregivers and family members with ADRD within the clinic would be beneficial in closing this gap in care. The clinic employs a variety of disciplines who are capable of teaching in many areas which were identified as an unmet need. As of now, the clinic is only providing psychotherapy services for patients and caregivers who reported moderate to high levels of stress, anxiety, or depression. However, incorporating a program designed to inform, educate, support, and navigate the healthcare system, would bring in extra revenue, and help reduce health care cost associated with the burden of ADRD. The literature further indicates that case management services for these individuals is

imperative to help navigate the healthcare system due to the complexity of care. Since this clinic did not have any case managers, all patients were given a referral to their primary care providers to initiate case management services. It is recommended that this clinic strengthens their referral process to avoid a delay in services by going through primary care providers. Employing a case manager, partnering with community resources, and local agencies, would greatly benefit patients and their caregivers by allowing them to connect to resources faster.

Implications for Practice

With the misconception that nothing can be done for these individuals, the lack of available reimbursement incentives for services, and the fear that time constraints pose in conducting a thorough assessment, proactive and preventative steps that could enhance care are not commonly taken (Alzheimer's Association Expert Taskforce, 2016 & Fazio et al., 2018).

This pilot project proved that a face-to-face comprehensive assessment can successfully be completed within a 1.15-hour time frame, and there are several CPT codes available to bill for

44 this service. Within eight weeks, this pilot project which was limited to just one prescriber and one therapist to identify, screen, and care plan, billed \$2,617.64 for reimbursement services on ten patients. ^① Implementing the AA Cognitive Impairment Care Planning Toolkit organization-wide could potentially make the clinic \$331,430.40- \$466,272 a year. This was calculated by taking the number of active patients in the clinic (n=12,000) and multiplied against 8% of the estimated ADRD population (n=960). CPT codes 96132 in combination with 96138 reimburses \$172.62 and CPT code 99483 reimburses \$242.83. Reimbursable amounts were multiplied by n= 960 and multiplied by 2 since the guidelines recommend this assessment to be done twice a year.

The DNP prepared Advanced Practice Registered Nurses (APRN) was essential in executing organizational change within this outpatient clinic. DNP prepared APRNs are practice leaders, and experts at implementing research in the clinical setting (Sonson, 2013), thus having been trained to exhibit excellent clinical judgement, communication skills, conflict management strategies, leadership, professionalism, and business practices that help make systems more cost effective and efficient (Sonson, 2013). All of these qualities are imperative in operationalizing systems change, as well as altering the clinical culture to a more synergistic collaborative environment.

The role of the APRN is to manage patient outcomes in a holistic way, and this toolkit helps address the holistic picture of the patients needs by assessing the nine core domains the guidelines recommend: cognition, function, staging of cognitive impairment, decision-making, NPS, caregiver needs, medication review and reconciliation, safety, and advanced care planning, twice a year by individualizing care.

45

References

- Adelman, R., Tmanova, L., Delgado, D., Dion, S., & Lachs, M. (2014). Caregiver burden: A clinical review. *JAMA*, 311, 1052-1059. <https://doi.org/10.1001/jama.2014.304>
- Alzheimer's Association. (2018). ¹⁰ 2018 Alzheimer's disease facts and figures. Retrieved from <https://www.alz.org/media/Documents/facts-and-figures-2018-r.pdf>
- Alzheimer's Association. (2018). ¹ Cognitive assessment and care planning services: Alzheimer's Association expert task force recommendations and tools for implementation. Retrieved from <https://www.alz.org/careplanning/downloads/cms-consensus.pdf>
- Alzheimer's Association. (2018). ¹² What is dementia. Retrieved from <https://www.alz.org/alzheimers-dementia/what-is-dementia>
- ¹ Alzheimer's Association Expert Task Force. (2017). ¹ Cognitive impairment care planning toolkit. Retrieved from <https://www.alz.org/careplanning/downloads/care-planning-toolkit.pdf>
- ¹² Alzheimer's Association Expert Taskforce. (2016). ¹ Alzheimer's association's expert task force

- ¹ consensus statement on the CMS proposed billing code for assessment and care planning
- ⁸ for individuals with cognitive impairment. Retrieved from
- ¹ http://act.alz.org/site/DocServer/Taskforce_Consensus_Statement_FINAL.pdf?docID=51
- 841
- Alzheimer's Impact Movement. (2018). About the Alzheimer's impact movement. Retrieved from <https://alzimpact.org/about>
- American Academy of Neurology, American Psychiatric Association. (2016). Dementia management quality measurement set update. Retrieved from [https://www.aan.com/siteassets/home-page/policy-and-guidelines/quality/quality-](https://www.aan.com/siteassets/home-page/policy-and-guidelines/quality/quality-measurement-set-update.pdf)

measures/13sammeasureset_pg.pdf

46

Calkins, M. (2018). ^④ From research to application: Supportive and therapeutic environments for people living with dementia. *The Gerontologist*, 58, S114-S128.

<https://doi.org/10.1093/geront/gnx146>

Cunningham, N., Cunningham, T., & Roberston, J. (2018). Understanding and measuring the wellbeing of carers of people with dementia. *The Gerontologist*, 00, 1-13.

^④ <https://doi.org/10.1093/geront/gny018>

^① Family Caregiver Alliance. (2006). Caregivers count too! a toolkit to help practitioners assess the needs of family caregivers. Retrieved from

[https://www.caregiver.org/sites/caregiver.org/files/pdfs/Assessment_Toolkit_20060802.p](https://www.caregiver.org/sites/caregiver.org/files/pdfs/Assessment_Toolkit_20060802.pdf)

df

^④ Fazio, S., Pace, D., Maslow, K., Zimmerman, S., & Kallmyer, B. (2018). Alzheimer's

^④ Association dementia care practice recommendations. *The Gerontologist*, 58, S1-S9.

^④ <https://doi.org/doi:10.1093/geront/gnx182>

Feliciano, L., Horning, S., Klebe, K., Anderson, S., Cornwell, E., & Davis, H. (2013). Utility of the SLUMS as a cognitive screening tool among a nonveteran sample of older adults. *The American Journal of Geriatric Psychiatry*, 21, 623-630.

<https://doi.org/10.1016/j.jagp.2013.01.024>

Howland, M., Tatsouka, C., Smyth, K., & Sajatovic, M. (2016). Detecting change over time: A comparison of the SLUMS exam and the MMSE in older adults at risk for cognitive decline. *CNS Neuroscience & Therapeutics*, 22, 413-419.

<https://doi.org/10.1111/cns.12515>

47

Hudani, Z., & Rojas-Fernandez, C. (2016). A scoping review on medication adherence in older

^⑬ patients with cognitive impairment or dementia. *Research in Social and Administrative Pharmacy*, 12, 815-829. <https://doi.org/10.1016/j.sapharm.2015.11.011>

Livingston, G., Barber, J., Rapaport, P., Knapp, M., Griffin, M., King, D.,.... Cooper, C. (2014).

Long-term clinical and cost-effectiveness of psychological intervention for family carers of people with dementia: ^⑥ a single blind, randomized, controlled trial. *The Lancet Psychiatry*, 1(December), 539-548. [https://doi.org/10.1016/S2215-0366\(14\)00073-X](https://doi.org/10.1016/S2215-0366(14)00073-X)

Psychiatry, 1(December), 539-548. [https://doi.org/10.1016/S2215-0366\(14\)00073-X](https://doi.org/10.1016/S2215-0366(14)00073-X)

Maloney, B., & Lahiri, D. (2016). Epigenetics of dementia: understanding the disease as a transformation rather than a state. *The Lancet Neurology*, 15, 760-774. Retrieved from <https://www-clinicalkey-com.uiwtx.idm.oclc.org/#!/content/playContent/1-s2.0-S147444221600065X?returnurl=null&referrer=null>

④ Maslow, K., & Fortinsky, R. (2018). Nonphysician care providers can help to increase detection of cognitive impairment and encourage diagnostic evaluation for dementia in community and residential care settings. ④ *The Gerontologist*, 58, S20-S31. <https://doi.org/doi:10.1093/geront/gnx171>

Moelter, S., Glenn, M., Xie, S., Chittams, J., Clark, C., Watson, I., & Arnold, S. (2015). The dementia severity rating scale predicts clinical dementia rating sum of boxes scores.

⑬ *Alzheimer Disease and Associated Disorders*, 29, 158-160. ⑭ <https://doi.org/10.1097/WAD.0000000000000031>

④ Molony, S., Kolanowski, A., Van Haitsma, K., & Rooney, K. (2018). Patient-centered assessment and care planning. *The Gerontologist*, 58, S32-S47. <https://doi.org/10.1093/geront/gnx173>

48

Moriarty, A., Gilbody, S., McMillan, D., & Manea, L. (2015). Screening and case finding for major depressive disorder using the Patient Health Questionnaire (PHQ-9): a meta-analysis. *General Hospital Psychiatry*, 37, 567-576. <https://doi.org/10.1016/j.genhospsych.2015.06.012>

Musa, G., Henriquez, F., Muñoz-Neira, C., Delgado, C., Lillo, P., & Slachevsky, A. (2017). ① Utility of the neuropsychiatric inventory questionnaire (NPI-Q) in the assessment of a sample of patients with Alzheimer's disease in Chile. *Dement Neuropsychol*, 11, 129-136. <https://doi.org/10.1590/1980-57642016dn11-020005>

Odenheimer, G., Borson, S., Sanders, A., Swain-Eng, R., Kyomen, H., Tierney, S.,... Johnson, J. (2013). Quality improvement in neurology: Dementia management quality measures. *Journal of the American Geriatrics Society*, 62, 558-561. <https://doi.org/10.1111/jgs.12630>

Physician Consortium for Performance Improvement. (2011). Dementia performance measurement set. Retrieved from <http://neurofoundation.net/globals/axon/assets/9493.pdf>

④ Prizer, L., & Zimmerman, S. (2017). ④ Progressive support for activities of daily living for persons

living with dementia. *The Gerontologist*, 58, S74-S87.

<https://doi.org/10.1093/geront/gnx103>

Robinson, L., Bamford, C., Beyer, F., Clark, A., Emmer, C., Exley, C.,... Rousseau, N. (2010).

Patient preferences for future care- how can Advance Care Planning become embedded

⑩ into dementia care: A study protocol. *BMC Geriatrics*, 10(2), 1-6. Retrieved from

<https://bmcgeriatr.biomedcentral.com/articles/10.1186/1471-2318-10-2>

49

④ Scales, K., Zimmerman, S., & Miller, S. (2018). Evidence-based nonpharmacological practices

④ to address behavioral and psychological symptoms of dementia. *The Gerontologist*, 58,

S88-S102. ④ <https://doi.org/10.1093/geront/gnx167>

Schoenmakers, B., Buntinx, F., & DeLepeleire, J. (2010). Supporting the dementia family

caregiver: The effect of home care interventions on general well-being. *Aging and Mental*

Health, 14, 44-56. <https://doi.org/10.1080/13607860902845533>

Sonson, S. (2013). DNP-prepared APRNs: Leading the magnet charge. *Nursing Management*,

49-52. <https://doi.10.1097/01.NUMA.0000431425.39076.81>

Tataw, D. (2012). ⑩ Toward human resource management inter-professional health practice:

Linking organizational culture, group identity and individual autonomy. *Int J Health*

Plann Mgmt, 27, 130-149. ⑩ <https://doi.org/10.1002/hpm.2098>

Terum, T., Anderson, J., Rongve, A., Aarsland, D., Svendsboel, E., & Testad, I. (2017). The

relationship of specific items on the Neuropsychiatric Inventory to caregiver burden in

dementia: ⑩ A systematic review. ⑩ *The International Journal of Geriatric Psychiatry*, 32,

703-717. ⑩ <https://doi.org/10.1002/gps.4704>

⑩ The Gerontological Society of America Workgroup. (2017). Approaches and tools for primary

care providers. Retrieved from <https://www.geron.org/images/gsa/kaer/gsa-kaer->

[toolkit.pdf](https://www.geron.org/images/gsa/kaer/gsa-kaer-toolkit.pdf)

① The Workgroup on Alzheimer's Disease and Other Dementias. (2010). Practice guideline for the

⑥ treatment of patients with Alzheimer's disease and other dementias. Retrieved from

https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/alzhei

mers.pdf

50

U.S. (3) Department of Health and Human Services, National Institutes of Health, National Institute on Aging. (2017). (5) Basics of Alzheimer's disease and dementia. Retrieved from

(19) <https://www.nia.nih.gov/health/what-dementia>

(4) Whitlatch, C., & Orsulic-Jeras, S. (2018). Meeting the informational, educational, and (4) psychosocial support needs of persons living with dementia and their family caregivers.

The Gerontologist, 58, S58-S73. <https://doi.org/10.1093/geront/gnx162>

Wiener, J., Gould, E., Shuman, S., Kaur, R., & Ignaczak, M. (2016). (5) Examining models of dementia care. (ASPE Final Report No. 0212704.017.000.001). (5) Washington, D.C.: RTI

International

(3) World Health Organization. (2008). Age-friendly primary health care centres toolkit. Retrieved from https://www.who.int/ageing/publications/AF_PHC_Centretoolkit.pdf

51

Appendix A

Letter of Support

52

Appendix B

Medication List

(1) List all medications

Name of caregiver who assists with or oversees medication management:

Medications

Dose

Frequency

Review Date

53

Appendix C

(2) Dementia Severity Rating Scale (DSRS)

PARTICIPANT'S NAME: _____ DATE: _____ PERSON COMPLETING FORM: _____ Please circle the most appropriate answer. (2) Do you live with the participant? No Yes

(2) How much contact do you have with the participant? Less than 1 day per week 1 day/week 2 days/week 3-4 days/week 5 or more days per week Relationship to participant

(2) Self Spouse Sibling Child Other Family Friend Other _____ In each section, please circle the number that most closely applies to the participant. This is a general form,

so no one description may be exactly right -- please circle the answer that seems

to apply most of the time.

Please circle only one number per section, and be sure to answer all questions. MEMORY

0 Normal memory.

1 Occasionally forgets things that they were told recently. Does not cause many problems.

2 Mild consistent forgetfulness. Remembers recent events but often forgets parts.

3 Moderate memory loss. Worse for recent events. May not remember something you just told them. Causes problems with everyday activities.

4 Substantial memory loss. Quickly forgets recent or newly-learned things. Can only

remember things that they have known for a long time.

5 Does not remember basic facts like the day of the week, when last meal was eaten or what the next meal will be.

6 Does not remember even the most basic things.

54

SPEECH AND LANGUAGE

0 Normal ability to talk and to understand others.

1 Sometimes cannot find a word, but able to carry on conversations.

2 Often forgets words. May use the wrong word in its place. Some trouble expressing thoughts and giving answers.

3 Usually answers questions using sentences but rarely starts a conversation.

4 Answers questions, but responses are often hard to understand or don't make sense.

Usually able to follow simple instructions.

5 Speech often does not make sense. Can not answer questions or follow instructions.

6 Does not respond most of the time.

RECOGNITION OF FAMILY MEMBERS

0 Normal - recognizes people and generally knows who they are.

1 Usually recognizes grandchildren, cousins or relatives who are not seen frequently but may not recall how they are related.

2 Usually does not recognize family members who are not seen frequently. Is often

confused about how family members such as grandchildren, nieces, or nephews are related to them.

3 Sometimes does not recognize close family members or others who they see frequently. (2) May not recognize their children, brothers, or sisters who are not seen on

(2) a regular basis.

4 Frequently does not recognize spouse or caregiver.

5 No recognition or awareness of the presence of others.

ORIENTATION TO TIME

0 Normal awareness of time of day and day of week.

1 Some confusion about what time it is or what day of the week, but not severe enough to interfere with everyday activities.

2 Frequently confused about time of day.

3 Almost always confused about the time of day.

4 Seems completely unaware of time.

55

(2) ORIENTATION TO PLACE

0 Normal awareness of where they are even in new places.

1 Sometimes disoriented in new places.

2 Frequently disoriented in new places.

3 Usually disoriented, even in familiar places. May forget that they are already at home.

4 Almost always confused about place.

ABILITY TO MAKE DECISIONS

0 Normal - as able to make decisions as before.

1 Only some difficulty making decisions that arise in day-to-day life.

2 Moderate difficulty. Gets confused when things get complicated or plans change.

3 Rarely makes any important decisions. Gets confused easily.

4 Not able to understand what is happening most of the time.

SOCIAL AND COMMUNITY ACTIVITY

0 Normal - acts the same with people as before

1 Only mild problems that are not really important, but clearly acts differently from

previous years.

② 2 Can still take part in community activities without help. May appear normal to people who don't know them.

3 Often has trouble dealing with people outside the home without help from caregiver.

Usually can participate in quiet home activities with friends. The problem is clear to anyone who sees them.

4 No longer takes part in any real way in activities at home involving other people. Can

② only deal with the primary caregiver.

5 Little or no response even to primary caregiver.

56

② HOME ACTIVITIES AND RESPONSIBILITIES

0 Normal. ② No decline in ability to do things around the house.

1 Some problems with home activities. May have more trouble with money management (paying bills) and fixing things. Can still go to a store, cook or clean.

Still watches TV or reads a newspaper with interest and understanding.

2 Makes mistakes with easy tasks like going to a store, cooking or cleaning. Losing

② interest in the newspaper, TV or radio. Often can't follow a long conversation on a single topic.

② 3 Not able to shop, cook or clean without a lot of help. Does not understand the newspaper or the TV. Cannot follow a conversation.

4 No longer does any home-based activities.

PERSONAL CARE - CLEANLINESS

0 Normal. ② Takes care of self as well as they used to.

1 Sometimes forgets to wash, shave, comb hair, or may dress in wrong type of clothes. ② Not as neat as they used to be.

2 Requires help with dressing, washing and personal grooming.

3 Totally dependent on help for personal care.

EATING

② 0 Normal, does not need help in eating food that is served to them.

1 May need help cutting food or have trouble with some foods, but basically able to eat by themselves.

② 2 Generally able to feed themselves but may require some help. May lose interest during the meal.

② 3 Needs to be fed. May have trouble swallowing.

57

② CONTROL OF URINATION AND BOWELS

0 Normal - does not have problems controlling urination or bowels except for physical problems.

② 1 Rarely fails to control urination (generally less than one accident per month).

2 Occasional failure to control urination (about once a week or less).

3 Frequently fails to control urination (more than once a week).

4 Generally fails to control urination and frequently can not control bowels.

ABILITY TO GET FROM PLACE TO PLACE

0 Normal, able to get around on their own. (May have physical problems that require a cane or walker).

1 Sometimes gets confused when driving or taking public transportation, especially in new places. ② Able to walk places alone.

2 Cannot drive or take public transportation alone, even in familiar places. Can walk

② alone outside for short distances. Might get lost if walking too far from home.

3 Cannot be left outside alone. Can get around the house without getting lost or confused.

② 4 Gets confused and needs help finding their way around the house.

5 Almost always in a bed or chair. May be able to walk a few steps with help, but lacks sense of direction.

6 Always in bed. Unable to sit or stand.

INTERPRETATION Add up the points for all sections. Score 0-18 --- Mild 19-36 -- Moderate 37-54 -- Severe

Author:

Dr. ② Christopher M Clark, Alzheimer's Disease Core Center Department of Neurology, University of Pennsylvania, Philadelphia, Pennsylvania, USA

58

Appendix D

① KATZ Index of Independence in Activities of Daily Living

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)

Independence (1 Point)

NO supervision, direction or personal assistance.

Dependence (0 Points)

WITH supervision, direction, personal assistance or total care.

BATHING

Points: _____

① (1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.

(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing

DRESSING

Points: _____

① (1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.

(0 POINTS) Needs help with dressing self or needs to be completely dressed.

TOILETING

Points: _____

① (1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.

(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.

TRANSFERRING

Points: _____

① (1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable

(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.

CONTINENCE

Points: _____

① (1 POINT) Exercises complete self control over urination and defecation.

(0 POINTS) Is partially or totally incontinent of bowel or bladder

FEEDING

Points: _____

① (1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.

(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ SCORING: (1) 6 = High (patient independent) 0 = Low (patient very dependent)

59

Appendix E

(20) Lawton-Brody Instrumental Activities of Daily Living Scale

LAWTON - BRODY

(1) INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.) Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or I). A. (1) Ability to Use Telephone E. Laundry

I. (1) Operates telephone on own initiative-looks up and dials numbers, etc.

2. (21) Dials a few well-known numbers 3. Answers telephone but does not dial 4. (1) Does not use telephone at all

1

(1) 1 1 0

I. (22) Does personal laundry completely 2. (1) Launders small items-rinses stockings, etc. 3. (1) All laundry must be done by others

1 1 0

B. Shopping F. (1) Mode of Transportation

1. (23) Takes care of all shopping needs independently 2. (22) Shops independently for small purchases 3. (23) Needs to be accompanied on any shopping trip 4. (1) Completely unable to shop

1

(21) 0 0 0

1. (20) Travels independently on public transportation or drives own car

2. (22) Arranges own travel via taxi, but does not otherwise use public transportation

3. (22) Travels on public transportation when accompanied by another

4. (22) Travel limited to taxi or automobile with assistance of another

5. (1) Does not travel at all

1

1

1

0

0

C. (1) Food Preparation G. Responsibility for Own Medications

I. (20) Plans, prepares and serves adequate meals independently

2. (23) Prepares adequate meals if supplied with ingredients 3. (14) Heats, serves and prepares meals, or prepares meals,

22 or prepares meals but does not maintain adequate diet 4. 1 Needs to have meals prepared and served

1

0

0 0

1. 20 Is responsible for taking medication in correct dosages at correct time

2. 22 Takes responsibility if medication is prepared in advance in separate dosage

3. 1 Is not capable of dispensing own medication

1

0

0

D. Housekeeping H. 1 Ability to Handle Finances

1. 24 Maintains house alone or with occasional assistance (eg "heavy work domestic help")

2. 21 Performs light daily tasks such as dish washing, bed making

3. 25 Performs light daily tasks but cannot maintain acceptable level of cleanliness

4. 26 Needs help with all home maintenance tasks 5. 1 Does not participate in any housekeeping tasks

1

1

1

1 0

1. 22 Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income

2. 22 Manages day-to-day purchases, but needs help with banking, major purchases, etc.

3. 1 Incapable of handling money

1

1

0

Score

Score

1 Total Score _____ A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.

60

Appendix F

① My Stress Thermometer

My Stress Thermometer

STRESS: ① Feeling tense, nervous, anxious, restless, or unable to sleep because your mind is troubled all the time. *

① Please mark your current stress level on the thermometer:

Extremely stressed

Very stressed

Moderately stressed

A little stressed

Not stressed at all

Borson *Reference: ① Elo A-L, Leppänen A, Jahkola A. Scand J Work Environ Health 2003;29(6):444—451.

61

Appendix G

① Patient Health Questionnaire (PHQ-9)

62

Appendix H

Caregiver Profile

① Do you understand Alzheimer's disease and other dementias?

① Do you know where you can obtain additional information about the disease?

① Are you able and willing to provide care and/or assistance?

① Do you know where you can receive support as a caregiver?

63

Appendix I

VAMC SLUMS Examination

64

Appendix J

① Neuropsychiatric Inventory Questionnaire (NPI-Q)

NACC Uniform Data Set (UDS) – Initial Visit Packet

Form B5: Behavioral Assessment – Neuropsychiatric Inventory Questionnaire (NPI-Q1)

Center: _____ ADC Subject ID: _____ Form Date: ___/___/___ ADC Visit #: ___

NOTE: This form is to be completed by the clinician or other trained health professional per informant interview, as described Examiner's initials: ___ by the training video. (This is not to be completed by the subject as a paper-and-pencil self-report.) For information regarding NPI-Q Interviewer Certification, see UDS Coding Guidebook for Initial Visit Packet, Form B5.

Check only one box for each category of response.

1. NPI informant: 1 Spouse 2 Child 3 Other (specify): _____

2. DELUSIONS: 16 Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way? 2a. 1 0

2b. 10 1 2 3

3. HALLUCINATIONS:

16 Does the patient act as if he or she hears voices? Does he or she talk to people who are not there? 3a. 1 1 0 3b. 10 1 2 3

4. 16 AGITATION OR AGGRESSION: Is the patient stubborn and resistive to help from others? 4a. 1 1 0 4b. 10 1 2 3

5. 16 DEPRESSION OR DYSPHORIA: Does the patient act as if he or she is sad or in low spirits? Does he or she cry? 5a. 1

0 5b. 10 1 2 3

6. ANXIETY: 16 Does the patient become upset when separated from you? Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?

6a. 1 1 0 6b. 10 1 2 3

16 Please ask the following questions based upon changes. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no".

For each item marked "yes", rate the SEVERITY of the symptom (how it affects the patient): 1 = Mild (noticeable, but not a significant change) 2 = Moderate (significant, but not a dramatic change) 3 = Severe (very marked or prominent; a dramatic change)

1 Yes No Severity

65

(version 2.0, February 2008) Page 1 of 2 Center: _____ ADC Subject ID: _____ Form Date: ___/___/___ ADC Visit #: ___

NOTE: This form is to be completed by the clinician or other trained health professional per informant interview, as described by the training video. (This is not to be completed by the subject as a paper-and-pencil self-report.) For information regarding NPI-Q Interviewer Certification, see UDS Coding Guidebook for Initial Visit Packet, Form B5. Check only one box for each category of response.

16 Please ask the following questions based upon changes. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no".

For each item marked "yes", rate the SEVERITY of the symptom (how it affects the patient): 1 = Mild (noticeable, but not a significant change) 2 = Moderate (significant, but not a dramatic change)

3 = Severe (very marked or prominent; a dramatic change)

1 Yes No Severity

16. ELATION OR EUPHORIA: Does the patient appear to feel too good or act excessively happy? 7a. 0

7. 16 ELATION OR EUPHORIA: Does the patient appear to feel too good or act excessively happy? 7a. 0

7b. 3

8. 16 APATHY OR INDIFFERENCE: Does the patient seem less interested in his or her usual activities and in the activities and plans of others? 8a. 0 8b. 3

9. 16 DISINHIBITION: 16 Does the patient seem to act impulsively? For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings?

9a. 0 9b. 3

10. 16 IRRITABILITY OR LABILITY: Is the patient impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities? 10a. 0 10b. 3

11. 16 MOTOR DISTURBANCE: 16 Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?

11a. 0 11b. 3

12. 16 NIGHTTIME BEHAVIORS: 16 Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?

12a. 0 12b. 3

13. 16 APPETITE AND EATING: Has the patient lost or gained weight, or had a change in the food he or she likes? 13a. 0 13b. 3

UDS Initial Form B5: Behavioral Assessment–NPI-Q (version 2.0, February 2008) Page 2 of 2

1 1 1 2

1 1 2

1 1 2

1 1 2

1 1 2

1 1 2

1 1 2

66

Appendix K

12 Safety Assessment Checklist

1 Safety Assessment Checklist If the patient or caregiver answers yes to questions 1 and 3-7 or no to question 2, refer to the Safety Assessment Guide for further evaluation. When working with patients living with dementia, it is recommended that you also consult with a family member, 1 friend or caregiver, as the patient's judgment, memory and decreased cognitive skills may impact insight into the illness and the ability to provide accurate reporting.

Questions Yes No

1. 1 Is the patient still driving?

2. 1 Is the patient taking medications as prescribed?

3. 1 Are there concerns about safety in the home?

4. 1 Has the patient gotten lost in familiar places or wandered?

5. ① Are firearms present in the home?
6. ① Has the patient experienced unsteadiness or sustained falls?
7. ① Does the patient live alone?

67

Appendix L

- ① End-of-Life Checklist

68

Appendix M

- ① Decision Making Capacity

69

Appendix N

Resources- National and Local

70

Community Resources

Alamo Area Agency on Aging (AACOG / AAA) *hablan espanol*

Website: www.alamoaging.org Phone: 210-477-3275 / 1-866-231-4922

8700 Tesoro Drive Suite 700 San Antonio, TX 78217-6228

If you live in Atascosa, Bandera, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, McMullen, Medina, and

www.aacog.com/65/Alamo-Area-Agency-on-Aging

Offers Benefits Counseling - Provides assistance to seniors 60 years of age and older and Medicare beneficiaries of any age concerning their public benefits and entitlements.

Care Coordination - Assesses the needs of people 60 years of age and older and then coordinates local resources to support an individual's highest level of functioning.

Caregiver Support - Assesses needs of caregivers and then coordinates available support services. Information, Referral, and Assistance - Provides information and assistance to callers to identify and link with the appropriate service agencies. Nutrition - Serves nourishing meals on site and/or delivered to home-bound seniors. Ombudsman - Advocates for residents of long-term care communities (nursing homes and assisted living communities). Senior Centers - Local neighborhood facilities providing organization and provision of support services and recreational and group activities for the older person. Transportation - Offers door-to-door trips to nutrition sites, local medical services, and social service agency appointments.

Alzheimer's Association/San Antonio & South Texas Chapter *hablan espanol y página web traducida en español

Website: www.alz.org/sanantonio

Phone: 210-822-6449 24- Hour Helpline: ① 1-800-272-3900

7400 Louis Pasteur, Suite 200 San Antonio, TX 78229

San Antonio, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, McMullen, Medina, Wilson counties

Serving Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, McMullen, Medina, Wilson counties

Offers Care consultations- by phone or in person to caregivers Lending library- of books and videos Advocacy Network- for rights of victims and their families Education- several educational programs, free of charge, such as Stress Busting Program for Caregivers. Online- free educational courses that offer information on the course of disease.
www.training.alz.org

* Information and referral * Education and training * Monthly support groups * Provides 24-hour assistance, no matter when or where the person is reported missing.

WellMed Charitable Foundation

Phone: 1-866-390-6491 Website: www.wellmedcharitablefoundation.org www.caregiversos.org

8637 Fredericksburg Rd. ⑦ Suite 100 San Antonio, TX 78240

Offers complimentary programs designs to support family caregivers on their caregiving journey, including wellness activities, information, support, and education. Caregivers SOS centers are staffed by a knowledgeable, caring specialist who help family members and friends who are caring for a loved one with Alzheimer's disease or dementia, as well as other chronic conditions such as stroke, cancer, diabetes, chronic lung disease and heart disease.

<http://www.alamoaging.org/> <http://www.alamoaging.org/> <http://atascosa.tx.networkofcare.org/aging/resource/find.cfm>

<http://www.aacog.com/index.aspx?NID=86>

http://atascosa.tx.networkofcare.org/aging/resource/tax_list.cfm?sw=TC-5500.8000&cat=18819

①⑨ <http://www.alz.org/sanantonio>

<http://www.alz.org/sanantonio>

71

Jefferson Outreach

Website: www.jeffersonoutreach.org Phone: 210-734-5016

2201 St. ⑦ Cloud San Antonio, TX 78228

Services

*Free transportation to doctors' appointments in the SA area *Referrals and resources to optimize quality of life for the patient and caregiver *Telephone reassurance to increase independence, provide support, encouragement, and safety checks

Grace Place

4306 NW Loop 410 (at Babcock) San Antonio, Texas 78229 Phone: 210-735-2589 Website: www.mowsatx.org/grace-place

504 Avenue E (at McCullough in Grace Lutheran Church) San Antonio, TX 78215 Phone: 210- 271-9396

Serving Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, McMullen, Medina, Wilson

Services

Grace Place is an Alzheimer's- specific adult activity center providing caregiver respite, caregiver support, groups and community education. The activities focus on the strengths and remaining abilities of clients and are conducted by trained dementia care staff.

Offers *Meals on wheels * adult activity centers across the San Antonio area * caregiver support, education, and respite

Comprehensive Senior Centers Offering San Antonio and Bexar County seniors 60+ comprehensive resource facilities where seniors can congregate to

share meals, participate in activities and access needed services

West End Park Senior Center 1226 NW 18th Street San Antonio, TX 78207 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.207.1720

District 2 Senior Center 1751 South W.W. White Road San Antonio, TX 78220 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.207.5390

South Side Lions Senior Center 3303 Pecan Valley Dr. ⑦ San Antonio, TX 78210 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.207.1760

Willie M. Cortez Senior Center 5512 S.W. Military Drive San Antonio, TX 78242 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.207.5294

District 5 Senior Center 2701 S. Presa San Antonio, Texas 78210 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.207.5270

Normoyle Senior Center 700 Culberson San Antonio, Texas 78211 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.207.5650

Alicia Treviño López Senior Center 8353 Culebra Road San Antonio, TX 78251 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.558.0178

Doris Griffin Senior Center 6157 NW Loop 410 San Antonio, TX 78238 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.780.7444

Bob Ross Senior Center 2219 Babcock San Antonio, TX 78229 Hours: 7:00 a.m. - 4:00 p.m. (Monday - Friday) 210.207.5300

Northeast Senior Center 4135 Thousand Oaks San Antonio, TX 78217 Hours:700-4:00pm Monday -Friday 210-207-4590

Conducting a multicomponent needs assessment for caregivers will help to better understand their individualized needs and assist with improved care planning efforts (Whitlatch & Orsulic-Jeras, 2018). ① The Cognitive Impairment Care Planning Toolkit con... ② Do you live with the participant? No Yes Relationship to participant MEMORY SPEECH AND LANGUAGE RECOGNITION OF FAMILY MEMBERS ORIENTATION TO TIME ORIENTATION TO PLACE ABILITY TO MAKE DECISIONS SOCIAL AND COMMUNITY ACTIVITY HOME ACTIVITIES AND RESPONSIBILITIES PERSONAL CARE - CLEANLINESS EATING CONTROL OF URINATION AND BOWELS ABILITY TO GET FROM PLACE TO PLACE Form B5: Behavioral Assessment – Neuropsychiatric Inventory Questionnaire (NPI-Q1) Alzheimer's Association/San Antonio & South Texas Chapter

Source Matches (248)

① alz 68%	
Student paper Implementing a Cognitive Impairment Care Planning Toolkit to Enhance Dementia Care:	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

① alz 100%	
Student paper TABLE OF CONTENTS	Original source TABLE OF CONTENTS

① alz 87%	
Student paper Caregiver Identification and Needs Assessment26	Original source Caregiver identification and needs assessment

② alz 77%	
Student paper Appendix C Dementia Severity Rating Scale (DSRS)53	Original source DEMENCIA SEVERITY RATING SCALE (DSRS)

① alz 73%	
Student paper Appendix D KATZ Index of Independence in Activities of Daily Living58 Appendix E Lawton-Brody Instrumental Activities of Daily Living59	Original source Katz Index of Independence in Activities of Daily Living Lawton-Brody Instrumental Activities of Daily Living Scale (IADL) 18

1 alz 72%	
Student paper Appendix J Neuropsychiatric Inventory Questionnaire (NPI-Q)64	Original source The Neuropsychiatric Inventory Questionnaire (NPI-Q) 26

3 hhs 82%	
Student paper have Alzheimer's disease and related dementias (ADRD).	Original source Alzheimer's Disease and Related Dementias

1 alz 63%	
Student paper Cognitive Impairment Care Planning Toolkit in an outpatient mental health clinic to enhance	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

1 alz 68%	
Student paper Implementing a Cognitive Impairment Care Planning Toolkit to Enhance Dementia Care:	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

4 wsimg 78%	
Student paper The Alzheimer's Association Dementia Care	Original source Alzheimer's Association Dementia Care Practice Recommendations

5 hhs 100%	
Student paper Department of Health and Human Services,	Original source Department of Health and Human Services

6 hta 69%	
Student paper Alzheimer's disease (AD), vascular	Original source AD = Alzheimer's disease

7 bib 62%	
Student paper The Workgroup on Alzheimer's Disease and Other	Original source and Alzheimer's disease

8 chestervetclinic 67%	
Student paper • Stage of cognitive impairment	Original source cognitive impairment, including

1 alz 66%	
Student paper • Medication review and reconciliation	Original source • Medication reconciliation and review for high-risk medications

1 alz 100%	
Student paper • Caregiver identification and needs assessment	Original source Caregiver identification and needs assessment

1 alz 67%	
Student paper The Alzheimer's Association Expert Task Force (2017) has published a care planning	Original source Alzheimer's Association Expert Task Force

1 alz 64%	
Student paper it requires a written care plan (Alzheimer's Association Expert Task Force, 2017).	Original source Alzheimer's Association Expert Task Force

1 alz 64%	
Student paper terminology (CPT) code 99483 (Alzheimer's Association Expert Task Force, 2016).	Original source Alzheimer's Association Expert Task Force

9 hhs 100%	
Student paper The U.S.	Original source The U.S

5 hhs 66%	
Student paper Department of Health	Original source Department of Health & Human Services

1 alz 65%	
Student paper assessing each domain contained in the AA Cognitive Impairment Care Planning Toolkit	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

10 springermedizin 82%	
Student paper The Saint Louis University Mental Status examination (SLUMS) is one of many valid	Original source Saint Louis University Mental Status Examination (SLUMS)

7 bib 64%	
Student paper time (Feliciano et al., 2013).	Original source Sitek et al., 2013)

1 alz 73%	
Student paper in the geriatric population (Alzheimer's Association Expert Task Force, 2017;	Original source Alzheimer's Association Expert Task Force

2 alz 68%	
Student paper The Dementia Severity Rating Scale (DSRS) is valid and reliable tool that effectively	Original source DEMENTIA SEVERITY RATING SCALE (DSRS)

1 alz 68%	
Student paper The Neuropsychiatric Inventory Questionnaire (NPI-Q) is a quick, valid and reliable	Original source The Neuropsychiatric Inventory Questionnaire (NPI-Q) 26

11 springerpflege 82%	
Student paper In a meta-analysis by	Original source a meta-analysis

1 alz 66%	
Student paper Medication Review and Reconciliation	Original source • Medication reconciliation and review for high-risk medications

1 alz 67%	
Student paper adults, however, the Cognitive Impairment Care Planning Toolkit (2017) contains a safety	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

1 alz 100%	
Student paper Caregiver Identification and Needs Assessment	Original source Caregiver identification and needs assessment

7 bib 76%	
Student paper et al., 2014; Odenheimer et al., 2013;	Original source (Beaufils et al., 2014) Sitek et al., 2013)

10 springermedizin 64%	
Student paper In a systematic review of previously published	Original source A systematic review

① <i>alz</i> 65%	
Student paper My Stress Thermometer is a quick and easy	Original source My Stress Thermometer

① <i>alz</i> 62%	
Student paper Expert Task Force, 2017).	Original source Alzheimer's Association Expert Task Force

① <i>alz</i> 80%	
Student paper The Cognitive Impairment Care Planning Toolkit contains a caregiver	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

① <i>alz</i> 68%	
Student paper and willingness to provide care (Alzheimer's Association Expert Task Force, 2017).	Original source Alzheimer's Association Expert Task Force

④ <i>wsimg</i> 71%	
Student paper Whitlatch & Orsulic-Jeras, 2018).	Original source Whitlatch, C., & Orsulic-Jeras, S

④ <i>wsimg</i> 71%	
Student paper Whitlatch & Orsulic-Jeras, 2018).	Original source Whitlatch, C., & Orsulic-Jeras, S

⑥ <i>hta</i> 82%	
Student paper Robinson et al., 2010).	Original source Robinson et al

⑥ <i>hta</i> 82%	
Student paper Robinson et al., 2010).	Original source Robinson et al

① <i>alz</i> 63%	
Student paper assessment protocol such as the AA Cognitive Impairment Care Planning Toolkit in a mental	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

① <i>alz</i> 67%	
Student paper screening instruments recommended by the AA Cognitive Impairment Care Planning Toolkit	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

① <i>alz</i> 90%	
Student paper Caregiver needs assessment My Stress Thermometer	Original source Caregiver identification and needs assessment My Stress Thermometer

⑧ <i>chestervetclinic</i> 67%	
Student paper Since 6 (55%)	Original source 6:345-55

① <i>alz</i> 75%	
Student paper Implementing the AA Cognitive Impairment Care Planning Toolkit organization-	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

⑩ <i>springermedizin</i> 86%	
Student paper 2018 Alzheimer's disease facts and figures.	Original source Alzheimer's Disease Facts and Figures

① alz 100%	
Student paper Cognitive assessment and care planning services:	Original source Cognitive Assessment and Care Planning Services

⑧ chestervetclinic 68%	
Student paper for individuals with cognitive impairment.	Original source adults with cognitive impairment

① alz 93%	
Student paper Association expert task force recommendations and tools for implementation.	Original source Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation

① alz 90%	
Student paper http://act.alz.org/site/DocServer/Taskforce_Consensus_Statement_FINAL.pdf?docID=51	Original source http://act.alz.org/site/DocServer/Taskforce_Consensus_Statement_FINAL

⑫ alz 100%	
Student paper What is dementia.	Original source What Is Dementia

④ wsimg 84%	
Student paper From research to application: Supportive and therapeutic environments for people living with dementia. The Gerontologist, 58, S114-S128.	Original source From research to application Supportive and therapeutic environments for people living with dementia Know the person living with dementia The Gerontologist, 58, S114-S128

① alz 100%	
Student paper Alzheimer's Association Expert Task Force.	Original source Alzheimer's Association Expert Task Force

④ wsimg 82%	
Student paper https://doi.org/10.1093/geront/gnx146	Original source doi:10.1093/geront/gnx146

① alz 100%	
Student paper Cognitive impairment care planning toolkit.	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

④ wsimg 66%	
Student paper https://doi.org/10.1093/geront/gny018	Original source doi:10.1093/geront/gnx182

⑫ alz 68%	
Student paper Alzheimer's Association Expert Taskforce.	Original source The Alzheimer's Association Expert Taskforce recommendations and tools for implementation

① alz 100%	
Student paper Family Caregiver Alliance.	Original source Family Caregiver Alliance

① alz 74%	
Student paper Alzheimer's association's expert task force consensus statement on the CMS proposed billing code for assessment and care planning	Original source Alzheimer's Association Expert Task Force Alzheimer's Association Expert Task Force Consensus Statement on CMS Proposed Billing Code for the Assessment and Care Planning for Individuals with Cognitive Impairment

④ wsimg 66%	
Student paper Fazio, S., Pace, D., Maslow, K., Zimmerman, S., & Kallmyer, B.	Original source Fazio, S., Pace, D., Flinger, J., & Kallmyer, B

④ <i>wsimg</i> 89%	
Student paper Association dementia care practice recommendations.	Original source Alzheimer's Association Dementia Care Practice Recommendations

④ <i>wsimg</i> 76%	
Student paper https://doi.org/doi:10.1093/geront/gnx182	Original source doi:10.1093/geront/gnx182

⑬ <i>Student paper</i> 65%	
Student paper patients with cognitive impairment or dementia.	Original source mild cognitive impairment and dementia

⑥ <i>hta</i> 74%	
Student paper a single blind, randomized, controlled trial.	Original source A randomized controlled trial

④ <i>wsimg</i> 100%	
Student paper Maslow, K., & Fortinsky, R.	Original source Maslow, K., & Fortinsky, R

④ <i>wsimg</i> 62%	
Student paper of cognitive impairment and encourage diagnostic evaluation for dementia in community	Original source Non-physician care providers can help to increase detection of cognitive impairment and encourage diagnostic evaluation for dementia in community and residential care settings

④ <i>wsimg</i> 88%	
Student paper The Gerontologist, 58, S20-S31. https://doi.org/doi:10.1093/geront/gnx171	Original source The Gerontologist, 58, S20-S31 doi:10.1093/geront/gnx171

⑬ <i>Student paper</i> 69%	
Student paper Alzheimer Disease and Associated Disorders, 29, 158-160.	Original source Alzheimer Disease and Associated Disorders,

⑭ <i>Student paper</i> 63%	
Student paper https://doi.org/	Original source https://consultgeri.org

⑮ <i>Student paper</i> 73%	
Student paper 10.1097/WAD.0000000000000031	Original source 10.1097/wad.0b013e3182263edc

④ <i>wsimg</i> 100%	
Student paper Molony, S., Kolanowski, A., Van Haitsma, K., & Rooney, K.	Original source Molony, S., Kolanowski, A., Van Haitsma, K., & Rooney, K

④ <i>wsimg</i> 86%	
Student paper assessment and care planning. The Gerontologist, 58, S32-S47. https://doi.org/10.1093/geront/gnx173	Original source Person-centered assessment and care planning The Gerontologist, 58, S32-S47 doi:10.1093/geront/gnx173

① <i>alz</i> 72%	
Student paper Utility of the neuropsychiatric inventory questionnaire (NPI-Q) in the assessment of a	Original source The Neuropsychiatric Inventory Questionnaire (NPI-Q) 26

④ <i>wsimg</i> 100%	
Student paper Prizer, L., & Zimmerman, S.	Original source Prizer, L., & Zimmerman, S

4	<i>wsimg</i>	85%
Student paper	Original source	
Progressive support for activities of daily living for persons living with dementia. The Gerontologist, 58, 574-587. https://doi.org/10.1093/geront/gnx103	Progressive support for activities of daily living for persons living with dementia Know the person living with dementia The Gerontologist, 58, 574-587 doi:10.1093/geront/gnx103	

16	<i>Student paper</i>	65%
Student paper	Original source	
into dementia care:	(2003) Dementia Care	

4	<i>wsimg</i>	100%
Student paper	Original source	
Scales, K., Zimmerman, S., & Miller, S.	Scales, K., Zimmerman, S., & Miller, S	

4	<i>wsimg</i>	63%
Student paper	Original source	
to address behavioral and psychological symptoms of dementia. The Gerontologist, 58,	Evidence-based nonpharmacological practices for behavioral and psychological symptoms of dementia The Gerontologist, 58, S48-S57	

4	<i>wsimg</i>	82%
Student paper	Original source	
https://doi.org/10.1093.geront/gnx167	doi:10.1093/geront/gnx167	

17	<i>ProQuest document</i>	93%
Student paper	Original source	
Toward human resource management inter-professional health practice: Linking organizational culture, group identity and individual autonomy.	(2012), "Toward Human Resource Management in Inter-Professional Health Practice Linking Organizational Culture, Group Identity and Individual Autonomy."	

17	<i>ProQuest document</i>	82%
Student paper	Original source	
https://doi.org/10.1002/hpm.2098	doi:10.1002/hpm .2098	

10	<i>springermedizin</i>	100%
Student paper	Original source	
A systematic review.	A systematic review	

16	<i>Student paper</i>	87%
Student paper	Original source	
The International Journal of Geriatric Psychiatry, 32,	International Journal of Geriatric Psychiatry	

18	<i>psychiatrienet</i>	66%
Student paper	Original source	
https://doi.org/10.1002/gps.4704	DOI 10.1002/gps.2508	

19	<i>hhs</i>	71%
Student paper	Original source	
The Gerontological Society of America Workgroup.	Gerontological Society of America Report	

1	<i>alz</i>	66%
Student paper	Original source	
The Workgroup on Alzheimer's Disease and Other Dementias.	Do you understand Alzheimer's disease and other dementias	

6	<i>hta</i>	67%
Student paper	Original source	
treatment of patients with Alzheimer's disease and other dementias.	With Alzheimer's Disease and Related Dementias	

<p>3 hhs 88%</p>	
<p>Student paper</p> <p>Department of Health and Human Services, National Institutes of Health, National Institute</p>	<p>Original source</p> <p>Department of Health and Human Services, National Institutes of Health</p>

<p>3 hhs 86%</p>	
<p>Student paper</p> <p>World Health Organization.</p>	<p>Original source</p> <p>WHO World Health Organization</p>

<p>5 hhs 82%</p>	
<p>Student paper</p> <p>Basics of Alzheimer's disease and dementia.</p>	<p>Original source</p> <p>Dementia and Alzheimer's Disease</p>

<p>1 alz 92%</p>	
<p>Student paper</p> <p>List all medications Name of caregiver who assists with or oversees medication management:</p>	<p>Original source</p> <p>List all current medications Name of caregiver who assists with or oversees medication management</p>

<p>19 hhs 69%</p>	
<p>Student paper</p> <p>https://www.nia.nih.gov/health/what-dementia</p>	<p>Original source</p> <p>https://www.nia.nih.gov/alzheimers/alzheimers-and-dementia-resources-professionals</p>

<p>2 alz 100%</p>	
<p>Student paper</p> <p>Dementia Severity Rating Scale (DSRS)</p>	<p>Original source</p> <p>DEMENTIA SEVERITY RATING SCALE (DSRS)</p>

<p>4 wsimg 100%</p>	
<p>Student paper</p> <p>Whitlatch, C., & Orsulic-Jeras, S.</p>	<p>Original source</p> <p>Whitlatch, C., & Orsulic-Jeras, S</p>

<p>2 alz 100%</p>	
<p>Student paper</p> <p>Do you live with the participant?</p>	<p>Original source</p> <p>Do you live with the participant</p>

<p>4 wsimg 80%</p>	
<p>Student paper</p> <p>psychosocial support needs of persons living with dementia and their family caregivers. The Gerontologist, 58, S58-S73. https://doi.org/10.1093/geront/gnx162</p>	<p>Original source</p> <p>Meeting the informational, educational, and psychosocial support needs of persons living with dementia and their family caregivers The Gerontologist, 58, S58-S63 doi:10.1093/geront/gnx162</p>

<p>2 alz 100%</p>	
<p>Student paper</p> <p>How much contact do you have with the participant?</p>	<p>Original source</p> <p>How much contact do you have with the participant</p>

<p>5 hhs 66%</p>	
<p>Student paper</p> <p>Examining models of</p>	<p>Original source</p> <p>The Examining Models of Dementia Care</p>

<p>2 alz 88%</p>	
<p>Student paper</p> <p>Self Spouse Sibling Child Other Family Friend Other _____ In each section, please circle the number that most closely applies to the participant. This is a general form, so no one description may be exactly right - please circle the answer that seems to apply most of the time. Please circle only one number per section, and be sure to answer all questions.</p>	<p>Original source</p> <p>In each section, please circle the number that most closely applies to the participant is a general form, so no one description may be exactly right -- please circle the answer that seems to apply most of the time Please circle only one number per section, and be sure to answer all questions</p>

<p>5 hhs 100%</p>	
<p>Student paper</p> <p>Washington, D.C.:</p>	<p>Original source</p> <p>Washington, D.C</p>

2 alz	100%
Student paper 0 Normal memory. 1 Occasionally forgets things that they were told recently. Does not cause many problems. 2 Mild consistent forgetfulness.	Original source 0 Normal memory 1 Occasionally forgets things that they were told recently Does not cause many problems 2 Mild consistent forgetfulness

2 alz	100%
Student paper Remembers recent events but often forgets parts. 3 Moderate memory loss. Worse for recent events. May not remember something you	Original source Remembers recent events but often forgets parts 3 Moderate memory loss Worse for recent events May not remember something you

2 alz	100%
Student paper just told them. Causes problems with everyday activities. 4 Substantial memory loss. Quickly forgets recent or newly-learned things.	Original source just told them Causes problems with everyday activities 4 Substantial memory loss Quickly forgets recent or newly-learned things

2 alz	97%
Student paper remember things that they have known for a long time. 5 Does not remember basic facts like the day of the week, when last meal was eaten or what the next meal will be. 6 Does not remember even the most basic things.	Original source remember things that they have known for a long time 5 Does not remember basic facts like the day of the week, when last meal was eaten or what the next meal will be 6 Does not remember even the most basic things

2 alz	100%
Student paper SPEECH AND LANGUAGE 0 Normal ability to talk and to understand others. 1 Sometimes cannot find a word, but able to carry on conversations. 2 Often forgets words.	Original source SPEECH AND LANGUAGE 0 Normal ability to talk and to understand others 1 Sometimes cannot find a word, but able to carry on conversations 2 Often forgets words

2 alz	100%
Student paper May use the wrong word in its place. Some trouble expressing thoughts and giving answers. 3 Usually answers questions using sentences but rarely starts a conversation.	Original source May use the wrong word in its place Some trouble expressing thoughts and giving answers 3 Usually answers questions using sentences but rarely starts a conversation

2 alz	99%
Student paper 4 Answers questions, but responses are often hard to understand or don't make sense. Usually able to follow simple instructions. 5 Speech often does not make sense. Can not answer questions or follow instructions.	Original source 4 Answers questions, but responses are often hard to understand or don't make Usually able to follow simple instructions 5 Speech often does not make sense Can not answer questions or follow instructions

2 alz	100%
Student paper 6 Does not respond most of the time. RECOGNITION OF FAMILY MEMBERS 0 Normal - recognizes people and generally knows who they are. 1 Usually recognizes grandchildren, cousins or relatives who are not seen frequently	Original source 6 Does not respond most of the time RECOGNITION OF FAMILY MEMBERS 0 Normal - recognizes people and generally knows who they are 1 Usually recognizes grandchildren, cousins or relatives who are not seen frequently

2 alz	100%
Student paper but may not recall how they are related. 2 Usually does not recognize family members who are not seen frequently.	Original source but may not recall how they are related 2 Usually does not recognize family members who are not seen frequently

2 alz	100%
Student paper confused about how family members such as grandchildren, nieces, or nephews are related to them. 3 Sometimes does not recognize close family members or others who they see	Original source confused about how family members such as grandchildren, nieces, or nephews are related to them 3 Sometimes does not recognize close family members or others who they see

2 alz	100%
Student paper May not recognize their children, brothers, or sisters who are not seen on a regular basis. 4 Frequently does not recognize spouse or caregiver. 5 No recognition or awareness of the presence of others.	Original source May not recognize their children, brothers, or sisters who are not seen on a regular basis 4 Frequently does not recognize spouse or caregiver 5 No recognition or awareness of the presence of others

2 alz	95%
Student paper	Original source
ORIENTATION TO TIME 0 Normal awareness of time of day and day of week. 1 Some confusion about what time it is or what day of the week, but not severe enough to interfere with everyday activities.	ORIENTATION TO TIME 0 Normal awareness of time of day and day of week 1 Some confusion about what time it is or what day of the week, but not severe enough to interfere with everyday activities

2 alz	100%
Student paper	Original source
0 Normal - acts the same with people as before 1 Only mild problems that are not really important, but clearly acts differently from	0 Normal - acts the same with people as before 1 Only mild problems that are not really important, but clearly acts differently from

2 alz	100%
Student paper	Original source
2 Frequently confused about time of day. 3 Almost always confused about the time of day. 4 Seems completely unaware of time.	2 Frequently confused about time of day 3 Almost always confused about the time of day 4 Seems completely unaware of time

2 alz	100%
Student paper	Original source
2 Can still take part in community activities without help. May appear normal to people who don't know them. 3 Often has trouble dealing with people outside the home without help from caregiver.	2 Can still take part in community activities without help May appear normal to people who don't know them 3 Often has trouble dealing with people outside the home without help from caregiver

2 alz	100%
Student paper	Original source
ORIENTATION TO PLACE 0 Normal awareness of where they are even in new places. 1 Sometimes disoriented in new places. 2 Frequently disoriented in new places.	ORIENTATION TO PLACE 0 Normal awareness of where they are even in new places 1 Sometimes disoriented in new places 2 Frequently disoriented in new places

2 alz	100%
Student paper	Original source
Usually can participate in quiet home activities with friends. The problem is clear to anyone who sees them. 4 No longer takes part in any real way in activities at home involving other people.	Usually can participate in quiet home activities with friends The problem is clear to anyone who sees them 4 No longer takes part in any real way in activities at home involving other people

2 alz	98%
Student paper	Original source
3 Usually disoriented, even in familiar places. May forget that they are already at home. 4 Almost always confused about place. ABILITY TO MAKE DECISIONS	3 Usually disoriented, even in familiar places May forget that they are already at 4 Almost always confused about place ABILITY TO MAKE DECISIONS

2 alz	100%
Student paper	Original source
only deal with the primary caregiver. 5 Little or no response even to primary caregiver.	only deal with the primary caregiver 5 Little or no response even to primary caregiver

2 alz	100%
Student paper	Original source
0 Normal - as able to make decisions as before. 1 Only some difficulty making decisions that arise in day-to-day life. 2 Moderate difficulty. Gets confused when things get complicated or plans change.	0 Normal - as able to make decisions as before 1 Only some difficulty making decisions that arise in day-to-day life 2 Moderate difficulty Gets confused when things get complicated or plans change

2 alz	100%
Student paper	Original source
HOME ACTIVITIES AND RESPONSIBILITIES	HOME ACTIVITIES AND RESPONSIBILITIES

2 alz	100%
Student paper	Original source
3 Rarely makes any important decisions. Gets confused easily. 4 Not able to understand what is happening most of the time. SOCIAL AND COMMUNITY ACTIVITY	3 Rarely makes any important decisions Gets confused easily 4 Not able to understand what is happening most of the time SOCIAL AND COMMUNITY ACTIVITY

2 alz	100%
Student paper	Original source
No decline in ability to do things around the house. 1 Some problems with home activities. May have more trouble with money management (paying bills) and fixing things.	No decline in ability to do things around the house 1 Some problems with home activities May have more trouble with money management (paying bills) and fixing things

② alz 100%	
Student paper Can still go to a store, cook or clean. Still watches TV or reads a newspaper with interest and understanding. 2 Makes mistakes with easy tasks like going to a store, cooking or cleaning.	Original source Can still go to a store, cook or clean Still watches TV or reads a newspaper with interest and understanding 2 Makes mistakes with easy tasks like going to a store, cooking or cleaning

② alz 100%	
Student paper interest in the newspaper, TV or radio. Often can't follow a long conversation on a	Original source interest in the newspaper, TV or radio Often can't follow a long conversation on a

② alz 100%	
Student paper 3 Not able to shop, cook or clean without a lot of help. Does not understand the newspaper or the TV. Cannot follow a conversation.	Original source 3 Not able to shop, cook or clean without a lot of help Does not understand the newspaper or the TV Cannot follow a conversation

② alz 100%	
Student paper 4 No longer does any home-based activities. PERSONAL CARE - CLEANLINESS	Original source 4 No longer does any home-based activities PERSONAL CARE - CLEANLINESS

② alz 100%	
Student paper Takes care of self as well as they used to. 1 Sometimes forgets to wash, shave, comb hair, or may dress in wrong type of	Original source Takes care of self as well as they used to 1 Sometimes forgets to wash, shave, comb hair, or may dress in wrong type of

② alz 100%	
Student paper Not as neat as they used to be. 2 Requires help with dressing, washing and personal grooming. 3 Totally dependent on help for personal care.	Original source Not as neat as they used to be 2 Requires help with dressing, washing and personal grooming 3 Totally dependent on help for personal care

② alz 99%	
Student paper 0 Normal, does not need help in eating food that is served to them. 1 May need help cutting food or have trouble with some foods, but basically able to eat by	Original source 0 Normal, does not need help in eating food that is served to them 1 May need help cutting food or have trouble with some foods, but basically able to eat

② alz 92%	
Student paper 2 Generally able to feed themselves but may require some help. May lose interest during	Original source 2 Generally able to feed themselves but may require some help May lose interest

② alz 100%	
Student paper 3 Needs to be fed. May have trouble swallowing.	Original source 3 Needs to be fed May have trouble swallowing

② alz 100%	
Student paper CONTROL OF URINATION AND BOWELS 0 Normal - does not have problems controlling urination or bowels except for physical	Original source CONTROL OF URINATION AND BOWELS 0 Normal - does not have problems controlling urination or bowels except for physical

② alz 100%	
Student paper 1 Rarely fails to control urination (generally less than one accident per month). 2 Occasional failure to control urination (about once a week or less). 3 Frequently fails to control urination (more than once a week). 4 Generally fails to control urination and frequently can not control bowels.	Original source 1 Rarely fails to control urination (generally less than one accident per month) 2 Occasional failure to control urination (about once a week or less) 3 Frequently fails to control urination (more than once a week) 4 Generally fails to control urination and frequently can not control bowels

② alz 100%	
Student paper ABILITY TO GET FROM PLACE TO PLACE 0 Normal, able to get around on their own. (May have physical problems that require a cane or walker).	Original source ABILITY TO GET FROM PLACE TO PLACE 0 Normal, able to get around on their own (May have physical problems that require a cane or walker)

② alz 100%	
Student paper	Original source
1 Sometimes gets confused when driving or taking public transportation, especially in	1 Sometimes gets confused when driving or taking public transportation, especially in

② alz 100%	
Student paper	Original source
Able to walk places alone. 2 Cannot drive or take public transportation alone, even in familiar places.	Able to walk places alone 2 Cannot drive or take public transportation alone, even in familiar places

② alz 100%	
Student paper	Original source
alone outside for short distances. Might get lost if walking too far from home. 3 Cannot be left outside alone. Can get around the house without getting lost or	alone outside for short distances Might get lost if walking too far from home 3 Cannot be left outside alone Can get around the house without getting lost or

② alz 100%	
Student paper	Original source
4 Gets confused and needs help finding their way around the house. 5 Almost always in a bed or chair. May be able to walk a few steps with help, but lacks sense of direction.	4 Gets confused and needs help finding their way around the house 5 Almost always in a bed or chair May be able to walk a few steps with help, but lacks sense of direction

② alz 97%	
Student paper	Original source
6 Always in bed. Unable to sit or stand. INTERPRETATION Add up the points for all sections.	6 Always in bed Unable to sit or stand Add up the points for all sections

② alz 70%	
Student paper	Original source
Christopher M Clark, Alzheimer's Disease Core Center Department of Neurology, University of Pennsylvania, Philadelphia, Pennsylvania, USA	Department of Neurology, University of Pennsylvania, Philadelphia, Pennsylvania, USA

① alz 100%	
Student paper	Original source
KATZ Index of Independence in Activities of Daily Living Katz Index of Independence in Activities of Daily Living Activities Points (1 or 0) Independence (1 Point)	Katz Index of Independence in Activities of Daily Living Katz Index of Independence in Activities of Daily Living Activities Points (1 or 0) Independence (1 Point)

① alz 100%	
Student paper	Original source
NO supervision, direction or personal assistance. Dependence (0 Points) WITH supervision, direction, personal assistance or total care.	NO supervision, direction or personal assistance Dependence (0 Points) WITH supervision, direction, personal assistance or total care

① alz 100%	
Student paper	Original source
(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity. (0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity (0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower Requires total bathing

① alz 100%	
Student paper	Original source
(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes. (0 POINTS) Needs help with dressing self or needs to be completely dressed.	(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners May have help tying shoes (0 POINTS) Needs help with dressing self or needs to be completely dressed

① alz 100%	
Student paper	Original source
(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help. (0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help (0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode

① alz 100%	
Student paper (1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable (0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.	Original source (1 POINT) Moves in and out of bed or chair unassisted Mechanical transfer aids are acceptable (0 POINTS) Needs help in moving from bed to chair or requires a complete transfer

① alz 100%	
Student paper (1 POINT) Exercises complete self control over urination and defecation. (0 POINTS) Is partially or totally incontinent of bowel or bladder	Original source (1 POINT) Exercises complete self control over urination and defecation (0 POINTS) Is partially or totally incontinent of bowel or bladder

① alz 100%	
Student paper (1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person. (0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.	Original source (1 POINT) Gets food from plate into mouth without help Preparation of food may be done by another person (0 POINTS) Needs partial or total help with feeding or requires parenteral feeding

① alz 100%	
Student paper 6 = High (patient independent) 0 = Low (patient very dependent	Original source 6 = High (patient independent) 0 = Low (patient very dependent

⑳ Student paper 91%	
Student paper Lawton-Brody Instrumental Activities of Daily Living Scale	Original source The Lawton Instrumental Activities of Daily Living Scale

① alz 87%	
Student paper INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.) Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).	Original source LAWTON - BRODY INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.) For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1)

① alz 100%	
Student paper Ability to Use Telephone E.	Original source Ability to Use Telephone E

① alz 73%	
Student paper Operates telephone on own initiative-looks up and dials numbers, etc.	Original source Operates telephone on own initiative-looks

㉑ Student paper 100%	
Student paper Dials a few well-known numbers 3. Answers telephone but does not dial 4.	Original source Dials a few well-known numbers 3 Answers telephone but does not dial 4

① alz 65%	
Student paper Does not use tele hone at all	Original source Does not use telephone at all

① alz 100%	
Student paper 1 1 0	Original source 1 1 0

㉒ Student paper 100%	
Student paper Does personal laundry completely 2.	Original source Does personal laundry completely 2

① alz 100%	
Student paper Launders small items-rinses stockings, etc.	Original source Launders small items-rinses stockings, etc

① alz 100%	
Student paper All laundry must be done by others 1 1 0	Original source All laundry must be done by others 1 1 0

① alz 100%	
Student paper Mode of Transportation	Original source Mode of Transportation

②③ Student paper 92%	
Student paper Takes care of all shopping needs independently 2.	Original source Takes care of all shopping needs independently (1) 2

②② Student paper 100%	
Student paper Shops independently for small purchases 3.	Original source Shops independently for small purchases 3

②③ Student paper 92%	
Student paper Needs to be accompanied on any shopping trip 4.	Original source Needs to be accompanied on any shopping trip (0) 4

① alz 100%	
Student paper Completely unable to shop	Original source Completely unable to shop

②① Student paper 63%	
Student paper 0 0 0	Original source 0 1 0

②⑩ Student paper 100%	
Student paper Travels independently on public transportation or drives own car	Original source Travels independently on public transportation or drives own car

②② Student paper 100%	
Student paper Arranges own travel via taxi, but does not otherwise use public transportation	Original source Arranges own travel via taxi, but does not otherwise use public transportation

②② Student paper 100%	
Student paper Travels on public transportation when accompanied by another	Original source Travels on public transportation when accompanied by another

②② Student paper 100%	
Student paper Travel limited to taxi or automobile with assistance of another	Original source Travel limited to taxi or automobile with assistance of another

① alz 100%	
Student paper Does not travel at all	Original source Does not travel at all

① alz 100%	
Student paper Food Preparation G. Responsibility for Own Medications	Original source Food Preparation G Responsibility for Own Medications

②⑩ Student paper 100%	
Student paper Plans, prepares and serves adequate meals independently	Original source Plans, prepares, and serves adequate meals independently

23 Student paper 93%	
Student paper Prepares adequate meals if supplied with ingredients 3.	Original source Prepares adequate meals if supplied with ingredients (0) 3

14 Student paper 85%	
Student paper Heats, serves and prepares meals, or prepares meals,	Original source Heats and serves prepared meals or prepares meals

22 Student paper 82%	
Student paper or prepares meals but does not maintain adequate diet 4.	Original source prepares meals, or prepares meals but does not maintain adequate diet

1 alz 100%	
Student paper Needs to have meals prepared and served	Original source Needs to have meals prepared and served

20 Student paper 100%	
Student paper Is responsible for taking medication in correct dosages at correct time	Original source Is responsible for taking medication in correct dosages at correct time

22 Student paper 100%	
Student paper Takes responsibility if medication is prepared in advance in separate dosage	Original source Takes responsibility if medication is prepared in advance in separate dosage

1 alz 100%	
Student paper Is not capable of dispensing own medication	Original source Is not capable of dispensing own medication

1 alz 100%	
Student paper Ability to Handle Finances	Original source Ability to Handle Finances

24 Student paper 100%	
Student paper Maintains house alone or with occasional assistance (eg "heavy work domestic help")	Original source Maintains house alone or with occasional assistance (eg "heavy work domestic help")

21 Student paper 94%	
Student paper Performs light daily tasks such as dish washing, bed making	Original source Performs light daily tasks such as dish- 1 washing, bed making

25 Student paper 100%	
Student paper Performs light daily tasks but cannot maintain acceptable level of cleanliness	Original source Performs light daily tasks, but cannot maintain acceptable level of cleanliness

26 Student paper 92%	
Student paper Needs help with all home maintenance tasks 5.	Original source Needs help with all home maintenance tasks.....1 5

1 alz 100%	
Student paper Does not participate in any housekeeping tasks	Original source Does not participate in any housekeeping tasks

22 Student paper 100%	
Student paper Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	Original source Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income

22 Student paper 100%	
Student paper Manages day-to-day purchases, but needs help with banking, major purchases, etc.	Original source Manages day-to-day purchases, but needs help with banking, major purchases, etc

1 alz 100%	
Student paper Incapable of handling money	Original source Incapable of handling money

1 alz 96%	
Student paper Total Score_____A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.	Original source A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias

1 alz 100%	
Student paper My Stress Thermometer My Stress Thermometer	Original source My Stress Thermometer My Stress Thermometer

1 alz 100%	
Student paper Feeling tense, nervous, anxious, restless, or unable to sleep because your mind is troubled all the time.	Original source Feeling tense, nervous, anxious, restless, or unable to sleep because your mind is troubled all the time.*

1 alz 100%	
Student paper Please mark your current stress level on the thermometer:	Original source Please mark your current stress level on the thermometer

1 alz 100%	
Student paper Elo A-L, Leppänen A, Jahkola A. Scand J Work Environ Health 2003;29(6):444-451.	Original source Elo A-L, Leppänen A, Jahkola A Scand J Work Environ Health 2003;29(6):444-451

1 alz 69%	
Student paper Patient Health Questionnaire (PHQ-9)	Original source Patient Health Questionnaire-2 (PHQ-2)

1 alz 68%	
Student paper Do you understand Alzheimer's	Original source Do you understand Alzheimer's disease and other dementias

1 alz 74%	
Student paper Do you know where you can obtain	Original source Do you know where you can obtain additional information about the disease

1 alz 74%	
Student paper Are you able and willing to provide	Original source Are you able and willing to provide care and/or assistance

1 alz 77%	
Student paper Do you know where you can receive	Original source Do you know where you can receive support as a caregiver

1 alz 90%	
Student paper Neuropsychiatric Inventory Questionnaire (NPI-Q)	Original source The Neuropsychiatric Inventory Questionnaire (NPI-Q) 26

16 Student paper 100%	
Student paper Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way?	Original source Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way

10 springermedizin 84%	
Student paper 1 2 3	Original source 1 2 3 4

10 springermedizin 84%	
Student paper 1 2 3	Original source 1 2 3 4

16 Student paper 100%	
Student paper DEPRESSION OR DYSPHORIA: Does the patient act as if he or she is sad or in low spirits? Does he or she cry?	Original source DEPRESSION OR DYSPHORIA Does the patient act as if he or she is sad or in low spirits Does he or she cry

16 Student paper 100%	
Student paper Does the patient act as if he or she hears voices? Does he or she talk to people who are not there?	Original source Does the patient act as if he or she hears voices Does he or she talk to people who are not there

10 springermedizin 84%	
Student paper 1 2 3	Original source 1 2 3 4

1 alz 63%	
Student paper 1 0 3b.	Original source 1 1 0

16 Student paper 100%	
Student paper Does the patient become upset when separated from you? Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?	Original source Does the patient become upset when separated from you Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense

10 springermedizin 84%	
Student paper 1 2 3	Original source 1 2 3 4

1 alz 63%	
Student paper 1 0 6b.	Original source 1 1 0

16 Student paper 100%	
Student paper AGITATION OR AGGRESSION: Is the patient stubborn and resistive to help from others?	Original source AGITATION OR AGGRESSION Is the patient stubborn and resistive to help from others

10 springermedizin 84%	
Student paper 1 2 3	Original source 1 2 3 4

1 alz 63%	
Student paper 1 0 4b.	Original source 1 1 0

<p>16 Student paper 87%</p>	
<p>Student paper</p> <p>Please ask the following questions based upon changes. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no". For each item marked "yes", rate the SEVERITY of the symptom (how it affects the patient):</p>	<p>Original source</p> <p>_____ Please ask the following questions based upon changes only if the symptom has been present in the past month otherwise, indicate "no" Rate the SEVERITY of the symptom (how it affects the patient)</p>

<p>16 Student paper 100%</p>	
<p>Student paper</p> <p>ELATION OR EUPHORIA: Does the patient appear to feel too good or act excessively happy?</p>	<p>Original source</p> <p>ELATION OR EUPHORIA Does the patient appear to feel too good or act excessively happy</p>

<p>16 Student paper 100%</p>	
<p>Student paper</p> <p>1 = Mild (noticeable, but not a significant change) 2 = Moderate (significant, but not a dramatic change) 3 = Severe (very marked or prominent);</p>	<p>Original source</p> <p>1 = Mild (noticeable, but not a significant change) 2 = Moderate (significant, but not a dramatic change) 3 = Severe (very marked or prominent)</p>

<p>16 Student paper 100%</p>	
<p>Student paper</p> <p>APATHY OR INDIFFERENCE: Does the patient seem less interested in his or her usual activities and in the activities and plans of others?</p>	<p>Original source</p> <p>APATHY OR INDIFFERENCE Does the patient seem less interested in his or her usual activities and in the activities and plans of others</p>

<p>1 alz 100%</p>	
<p>Student paper</p> <p>Yes No Severity</p>	<p>Original source</p> <p>Yes No SEVERITY</p>

<p>16 Student paper 100%</p>	
<p>Student paper</p> <p>Does the patient seem to act impulsively? For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings?</p>	<p>Original source</p> <p>Does the patient seem to act impulsively For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings</p>

<p>16 Student paper 87%</p>	
<p>Student paper</p> <p>Please ask the following questions based upon changes. Indicate "yes" only if the symptom has been present in the past month; otherwise, indicate "no". For each item marked "yes", rate the SEVERITY of the symptom (how it affects the patient):</p>	<p>Original source</p> <p>_____ Please ask the following questions based upon changes only if the symptom has been present in the past month otherwise, indicate "no" Rate the SEVERITY of the symptom (how it affects the patient)</p>

<p>16 Student paper 100%</p>	
<p>Student paper</p> <p>IRRITABILITY OR LABILITY: Is the patient impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities?</p>	<p>Original source</p> <p>IRRITABILITY OR LABILITY Is the patient impatient or cranky Does he or she have difficulty coping with delays or waiting for planned activities</p>

<p>16 Student paper 83%</p>	
<p>Student paper</p> <p>1 = Mild (noticeable, but not a significant change) 2 = Moderate (significant, but not a dramatic change)</p>	<p>Original source</p> <p>1 = Mild (noticeable, but not a significant change) 2 = Moderate (significant, but not a dramatic change) 3 = Severe (very marked or prominent)</p>

<p>16 Student paper 100%</p>	
<p>Student paper</p> <p>Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?</p>	<p>Original source</p> <p>Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly</p>

<p>1 alz 100%</p>	
<p>Student paper</p> <p>Yes No Severity</p>	<p>Original source</p> <p>Yes No SEVERITY</p>

<p>16 Student paper 100%</p>	
<p>Student paper</p> <p>Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?</p>	<p>Original source</p> <p>Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day</p>

16 Student paper 100%	
Student paper APPETITE AND EATING: Has the patient lost or gained weight, or had a change in the food he or she likes?	Original source APPETITE AND EATING Has the patient lost or gained weight, or had a change in the food he or she likes

1 alz 63%	
Student paper 1 1 2 1 1 2 1 1 2 1 1 2	Original source 1 1 0 1 1 0 1 1 0 1 1 0

1 alz 63%	
Student paper 1 1 2 1 1 2 1 1 2	Original source 1 1 0 1 1 0 1 1 0

12 alz 80%	
Student paper Safety Assessment Checklist	Original source Safety Assessment Guide and Checklist

1 alz 83%	
Student paper Safety Assessment Checklist If the patient or caregiver answers yes to questions 1 and 3-7 or no to question 2.	Original source Safety Assessment Checklist If the patient or caregiver answers yes to questions 1 and 3-7 or no to question 2, refer to the Safety Assessment Guide for further evaluation

1 alz 88%	
Student paper friend or caregiver, as the patient's judgment, memory and decreased cognitive skills may impact insight into the illness and the ability to provide accurate reporting. Questions Yes No	Original source When working with patients living with dementia, it is recommended that you also consult with a family member, friend or caregiver, as the patient's judgment, memory and decreased cognitive skills may impact insight into the illness and the ability to provide accurate reporting Questions Yes No

1 alz 100%	
Student paper Is the patient still driving?	Original source Is the patient still driving

1 alz 100%	
Student paper Is the patient taking medications as prescribed?	Original source Is the patient taking medications as prescribed

1 alz 100%	
Student paper Are there concerns about safety in the home?	Original source Are there concerns about safety in the home

1 alz 100%	
Student paper Has the patient gotten lost in familiar places or wandered?	Original source Has the patient gotten lost in familiar places or wandered

1 alz 100%	
Student paper Are firearms present in the home?	Original source Are firearms present in the home

1 alz 100%	
Student paper Has the patient experienced unsteadiness or sustained falls?	Original source Has the patient experienced unsteadiness or sustained falls

1 alz 100%	
Student paper Does the patient live alone?	Original source Does the patient live alone

① alz 100%	
Student paper End-of-Life Checklist	Original source END-OF-LIFE CHECKLIST

⑦ bib 71%	
Student paper Cloud San Antonio, TX 78228	Original source San Antonio, TX

① alz 80%	
Student paper Decision Making Capacity	Original source Decision making capacity assessment

⑦ bib 74%	
Student paper San Antonio, TX 78210 Hours:	Original source San Antonio, TX

① alz 84%	
Student paper 1-800-272-3900	Original source 800.272.3900

① alz 89%	
Student paper The Cognitive Impairment Care Planning Toolkit con...	Original source COGNITIVE IMPAIRMENT CARE PLANNING TOOLKIT

⑦ bib 63%	
Student paper Suite 100 San Antonio, TX 78240	Original source San Antonio, TX

② alz 100%	
Student paper Do you live with the participant?	Original source Do you live with the participant

①⑨ hhs 63%	
Student paper http://www.alz.org/sanantonio http://www.alz.org/sanantonio	Original source http://www.alz.org/publichealth/curriculum.asp http://www.alz.org/publichealth/curriculum.asp