

1: Team-Based Care | NIDDK

Alzheimer's disease in a changing health care system: falling through the cracks: hearing before the Special Committee on Aging, United States Senate, One Hundred Fourth Congress, second session, Washington, DC, April 23,

Does the model of managed care or integrated delivery system e. If so, are these effects quantitatively and clinically significant, compared to the effects that other variables such as income, education, or ethnicity have on patient outcomes? If the mode of health care delivery system appears to be related to patient care and outcomes, can specific organizational, financial, or other variables be identified to account for the relationships? If not, what research agenda should be pursued to provide critical information about the relationship between types of health care systems and the processes and outcomes of care delivered to populations with serious chronic conditions? As noted in the introduction to this report, the published evidence for differences in treatment received or outcomes achieved by RA and SLE patients in various health care delivery systems is practically nonexistent. The committee was unable to locate any such studies involving SLE. The most extensive comparison of delivery models and RA is that of Yelin and his colleagues, which he summarized for the committee at the workshop. They were unable to demonstrate significant differences between RA patients treated in fee-for-service FFS relationships and those treated in prepaid group practice health maintenance organizations HMOs. All patients received some care from a specialist rheumatologist. This finding is consistent with a larger body of data from studies of chronic diseases other than RA and SLE, although the data presented by Tarlov suggest that this may not hold true for certain vulnerable subsets of the chronically ill. The committee notes that lack of evidence for an effect does not constitute evidence for the absence of an effect, but the essentially negative answer to the first of the four questions in the charge would seem to rule out meaningful responses to questions 2 and 3, since they presuppose a positive answer to question 1. The rest of this chapter is therefore organized as a series of conclusions that the committee feels are justified by the current state of knowledge, and as recommendations for research that flow from these conclusions. The reader is referred to relevant portions of the workshop proceedings as appropriate. The committee alone bears full responsibility for the conclusions and recommendations. Conclusion 1 Rheumatoid arthritis and systemic lupus erythematosus are very likely to be representative of a large number of chronic diseases that will increasingly come to dominate U. The study of systems of care for chronic diseases such as RA and SLE demands integrated research and longitudinal studies, despite the inherent limitations imposed by changing health care practices, physician and patient characteristics, population demographics, and limited funds. The committee recommends that the National Institute of Arthritis and Musculoskeletal and Skin Diseases NIAMS seek additional funding to expand its research to include substantial support for high-quality studies that would allow a broad approach more closely linking scientific and technological advances to clinical trials, outcomes research, and health services research more generally. Although some of the required research is of the sort currently funded by the Agency for Health Care Policy and Research AHCPR, there is much to be said for bringing fundamental experimental research, clinical trials, and services or outcomes research on rheumatic disease under one roof, so that the benefits of a more coherent and unified approach might be realized. For example, studies might look at the way new technology is assessed and implemented in various types of managed care organizations and the rate of penetration and prevalence of application of medically accepted new technology in various types of managed care organizations. Conclusion 2 Differences in the incidence and severity of chronic diseases such as RA and SLE among individuals are more likely to be due to patient factors such as genetics, age, education, and socioeconomic status than to medical care organization and financing, but outcomes are likely to depend on all of these factors. Just as managed care is not a useful term because it encompasses such a wide variety of care delivery variations, people with RA and SLE vary widely. Disease severity, comorbid conditions, ethnicity, income, age, and education have already been identified as variables that are strongly associated with the course of these diseases and the response to some treatments. It is not unreasonable to suppose that other socioeconomic variables will be discovered to be relevant, and it is almost certain to be the case that each of these variables will render some interventions

highly desirable in certain cases and inappropriate in others. Studies of clinical interventions, health care delivery systems, and clinical course and outcomes should examine clinical, demographic, ethnic, and other subsets of patients with RA and SLE. Conclusion 3 Differences in delivery systems may well impact patient satisfaction and the types and intensity of interventions provided to RA and SLE patients, but to date there has been no clear and compelling demonstration of differential impact on the outcome or course of these diseases. As several speakers pointed out, the continuing evolution of health care delivery has already made simplistic comparisons such as managed care versus fee for service pointless or even misleading. Potentially relevant variables discussed at length at the workshop and often confounded in the existing literature assessing managed care are the method of payment capitation versus fee for service, for both patient-to-plan and plan-to-provider payments , specialty of the provider generalist versus subspecialist , and health and socioeconomic background of the enrolled population. Yelin, for example, pointed out that although his study of RA patients controlled for specialty type by drawing all of the subjects from the practices of California rheumatologists, this very consistency may well be the reason the study failed to reveal differences in treatment of patients in FFS and fully capitated HMOs. Method of payment, medical specialty of the provider, and initial health and socioeconomic background of the patient subjects should be carefully controlled in future studies or, preferably, studied in their own right, and measures of health status and function should be included in addition to simply noting the interventions provided. Conclusion 4 In addition to the pharmacologic and surgical interventions which are important elements of care for RA and SLE patients, several clinical and social interventions that are especially important for patient satisfaction and compliance, particularly strategies emphasizing the role of the patient in managing chronic diseases i. The incorporation of these clinical and social interventions into different health care delivery systems should be another area of research for NIAMS. In fact, the availability of such interventions would have to be considered in any evaluation of quality of care. Other research should focus on how these interventions might be improved and extended. For example, how can poorer, less educated patients and patients from different ethnic or cultural backgrounds be persuaded to take a more active role in the management of their rheumatic disease? Conclusion 5 The elderly, the poor, and the chronically ill may well be differentially and adversely affected by enrollment in prepaid health care plans or plans with strong incentives for providers to limit services. Some of the data presented by Davis and Schoen and the data presented by Tarlov point to a significant interaction between the delivery system and age, income, and health status. Davis and Schoen, for example, reported that respondents to a Commonwealth Fund managed care survey who rated their health as fair or poor or who reported that they or a family member had a serious illness in the past year, rated their plans quite differently depending on the type of plan providing their care. Figure 2 in the paper by Davis and Schoen, for example, shows that patients in managed care systems of all types were more likely to rate their plan fair or poor in providing access to specialists than were unmanaged fee-for-service patients. Tarlov suggested that this pattern in the data may be attributable to the relative cost of care for these groups. It may be that excessive medical costs have largely been incurred by a relatively healthy segment of the general population whereas expenditures for the aged, the poor, racial minorities, and those with chronic diseases have been more reflective of actual medical needs. Under such conditions, a general reduction of expenditures for health care would differentially impact these vulnerable subgroups even if care for the relatively healthy majority was not seriously compromised. Future research should examine interactions of patient factors and system factors, and their effects on costs, clinical course, and outcomes rather than attempt straightforward univariate comparisons of the sort suggested by question 2 above. Conclusion 6 It is generally believed that as many as 40 million Americans may be without health insurance of any kind. The charge to the committee assumes access to a health plan or health insurance by all persons with RA or SLE, but such access may be the most important determinant of care and outcome for all but the most affluent. Community-based samples that include nonmembers of health plans should be included in longitudinal studies of differential disease course and functional status of RA and SLE patients. The committee is concerned about access to plans, as well as services for enrolled patients once in a plan, and a potential advantage of the carve-out strategy is that it can remove or diminish the incentive for prepaid plans and fully capitated practices to avoid or discourage

enrollment by individuals likely to require far more services than the average enrollee. Plans could, for example, carve enrollees with preexisting RA out of their standard agreement, assign a rheumatologist as their primary care provider, charge a premium more in line with their expected outlay, and provide the rheumatologist with a higher than average capitation payment. NIAMS should encourage research investigating the possibility of increased access to health care plans by persons with RA and SLE where plans opt for, and states allow, such carve-outs. Conclusion 8 Checklists and health plan report cards developed for purposes of accreditation or consumer education are useful, but still primitive developments and by their nature are unlikely to provide answers to the questions posed to the committee. Quality-of-care measures need further development if delivery models health care plans are to be usefully evaluated. The aim of this effort is to provide a standard set of data that will be useful to consumers especially employers faced with choosing a health plan. Thus, it appears unlikely that report cards on health care plans will provide the type and quantity of data on specific chronic diseases that would allow valid comparisons of individual plans or plan types. With their defined populations and standardized treatment regimens, managed care plans represent a valuable research resource largely untapped to date. Privacy concerns must be addressed and resolved, but the committee recommends that NIAMS explore means of providing qualified researchers access to some of these databases as well as those associated with the Medicare and Medicaid experiments in managed care, with primary data from randomly selected member-patients to confirm the validity of the secondary data and fill in gaps in knowledge. Conclusion 9 The question of the optimal utilization of subspecialists is still unresolved. A considerable portion of workshop discussion concerned the role of the rheumatologist in the management of RA and SLE, the stimulus being the increasingly common use of a generalist "gatekeeper" by managed care plans to control access to subspecialists. Rheumatologists were the focus of the discussion at the workshop, but it was recognized by all participants that the arguments are by no means unique to rheumatology or even chronic disease. The committee was divided over the utility of further studies comparing treatment and outcomes of RA or SLE patients who have rheumatologists as their sole or primary provider with patients managed primarily by nonrheumatologists. On the one hand it was pointed out that there is already some evidence, including the work reported by Yelin at the workshop, that RA patients may fare somewhat better under rheumatologists, and that the literature as a whole probably supports the conclusion that, all other things being equal, patients of subspecialists generally fare better. A starting point for research might be an analysis of how specialty referral clinics and affiliated ancillary care providers achieve better outcomes when they do. Is this due to better diagnosis, more appropriate or more timely interventions, or better education and empowerment of patients and their families to name only a few possibilities? The committee agreed that some research on the nature of the referral process is certainly merited. Also deserving consideration would be studies investigating the cost-effectiveness of increased clinical training in chronic disease management for general internal medicine, family medicine, pediatrics, and geriatric specialists vis-a-vis continued investment in subspecialist training. A Final Note Managed care is a powerful and still growing element of U. Chronic disease is responsible for a large and growing proportion of health care utilization in the United States today, but those suffering from these diseases are also highly heterogeneous. The growth of both managed care and chronic disease have cast work force issues into bold relief, demanding reanalysis of the optimal roles of generalists and subspecialists. The interaction of managed care and chronic disease is a complex nexus that requires new research paradigms, which should be as integrative as possible.

2: Understanding the Health Care Team in Alzheimer's Disease | BrightFocus Foundation

*Alzheimer's disease in a changing health care system: Falling through the cracks: hearing before the Special Committee on Aging, United States Washington, DC, April 23, (S. hrg) [United States] on www.enganchecubano.com *FREE* shipping on qualifying offers.*

Team-Based Care Objective of Section To introduce concepts and models of team-based care and provide useful resources for integrating these elements into practice. Key Concepts Collaborative teams that provide continuous, supportive, and effective care for people with diabetes throughout the course of their disease serve as a model for the prevention and management of chronic diseases. Well-implemented diabetes team care can be cost-effective and the preferred method of care delivery, particularly when services include health promotion and disease prevention in addition to intensive clinical management. Team care is a key component of health care reform initiatives that incorporate an integrated health care delivery system, especially those for chronic disease prevention and management. Introduction Modern understanding of diabetes prevention and management advocates for the superiority of team-based care rooted in the primary care setting. High-functioning patient-centered teams work more efficiently and effectively to provide quality diabetes care and improve health outcomes. In turn, a fourth important aim emerges: Improving the patient experience of care including quality and satisfaction Improving the health of populations Reducing the per capita cost of health care The importance of team care is further highlighted by its inclusion in the Chronic Care Model and the Patient Centered Medical Home. The Chronic Care Model,⁶ which provides a framework for effective care of diabetes and other chronic diseases, incorporates team care as a vital component of delivery system design. The Patient Centered Medical Home model, which also includes team-based care, encourages a proactive approach to health promotion, disease prevention, and chronic disease management through the development of individualized care plans and effective health care team member communication and coordination of care. As such, transformation of practice and delivery system redesign are required to fully realize the potential of team-based care approaches. Practice transformation strategies, resources, and tools included in this section are designed to help primary care practices in developing team-based approaches that align with health care reform requirements. Information systems are a critical component of successful team-based care, helping facilitate decision support, effective and efficient communication, and information sharing among providers and patients. They also serve as a valuable population management tool. Learn more about how information systems can support team-based care. Let the Evidence Guide You – This PowerPoint presentation and associated CD from Improving Chronic Illness Care further explains the rationale behind health care reform and introduces potential strategies and considerations for practices. Chronic care clinics for diabetes in primary care: A system-wide randomized trial. Health care and patient-reported outcomes: Changing office practice and health care systems to facilitate diabetes self-management. Effects of quality improvement strategies for type 2 diabetes on glycemic control: Translating the chronic care model into the community: What will it take to improve care for chronic illness? Health Aff Millwood ; 29 5:

3: Alzheimer's disease - Symptoms and causes - Mayo Clinic

A Public Health Approach to Alzheimer's and Other Dementias is an introductory curriculum that is intended to increase awareness of the impact of Alzheimer's disease and other dementias as well as the role of public health. This curriculum addresses cognitive health, cognitive impairment, and Alzheimer's disease and is intended for use by.

Read now Vascular dementia Vascular dementia may occur when there is reduced circulation to the brain due to a stroke or other conditions, resulting in damage to the blood vessels in the brain. Dementia with Lewy bodies Dementia with Lewy bodies happens when abnormal proteins develop in the brain, called Lewy bodies. The protein deposits may be found throughout the brain, including the cerebral cortex, the area involved in language and thinking. Mixed dementia Mixed dementia involves more than one cause. Blood vessel problems may be present along with abnormal proteins in the brain, for example. How do symptoms of dementia change over time? Regardless of the cause, symptoms of dementia tend to worsen over time. The rate of progression varies from person to person. Genetics, age, and overall health may play a role in how fast the disease progresses. Early symptoms Dementia often, but not always, starts with a mild decline in the ability to think. For example, someone may forget a recent conversation or the name of a familiar object. Early symptoms may also include a decreased ability to perform certain tasks, such as paying bills or following a recipe. Subtle changes in personality may also be noticed by people close to an individual with dementia. At this stage, a person with dementia may start to realize something is not right, but they may choose to hide their symptoms. Moderate dementia symptoms Dementia may start with a decrease in memory. As dementia progresses, symptoms become harder to hide. More noticeable symptoms may develop. Help with self-care or everyday activities may be needed. Personality changes may become more noticeable. The person may experience paranoia or fear. Symptoms may include increased confusion and memory loss. People with moderate dementia commonly forget their address or other personal information, including their phone number. Sleep patterns and mood may change. Late-stage or severe dementia symptoms Gradually, dementia can progress and become severe. Memory is often significantly affected. Someone with dementia may not recognize family members. During late-stage dementia, symptoms may include an inability to communicate, walk, and control bowel and bladder function. A person with late-stage dementia may have muscle rigidity and abnormal reflexes. Full-time personal care is usually needed for eating, bathing, and dressing. People with severe dementia are vulnerable to infections, including pneumonia and bed sores. How do treatment options change over time? Treatment usually aims to decrease symptoms and manage behavioral changes. Treatment may also change over time. Different classifications of medication may be prescribed, based on the stage of the disease. Medications may reduce symptoms by affecting chemicals that carry messages to the brain cells. These drugs are called cholinesterase inhibitors. They are often prescribed for people with mild to moderate symptoms. Cholinesterase inhibitors treat symptoms associated with confusion, communication, and memory. In people with moderate-to-severe dementia, treatment may also include memantine. Memantine is a drug that may help improve language, thinking, and memory. Memantine works by regulating glutamate, a chemical in the brain that is involved in memory and learning. Memantine may delay the progression of symptoms temporarily for some people. Treatment options may include medications that reduce behavioral changes, such as anxiety and sleep problems. In later stages, different medications may be needed, as symptoms develop. Particular drugs may be recommended to treat specific symptoms, such as fear, restlessness, and hallucinations. As dementia progresses, treatment may also focus on improving the quality of life. For example, occupational therapy may be useful to teach people with dementia how to use adaptive equipment or to improve fine motor skills. Diagnosis and outcome A person with an early diagnosis of dementia may want to communicate their wishes for future care as soon as they can. No single test can determine if a person has dementia. Tests will focus on the ability to think and neurological evaluation. Tests evaluate skills such as reasoning, language, and memory. Movement, balance, and visual perception are also examined. A medical history and blood tests can help to rule out other causes of symptoms. Imaging studies, such as a CT or PET scan, can determine if a specific protein is deposited in the brain, or if there is any interruption to the blood flow to the brain. Dementia

scales can help to decide if dementia is present, and how far it has progressed. The Global Deterioration Scale may be used to determine the severity of overall dementia. Ratings range from one to seven, where seven indicates the most severe stage. A combination of tests may be used to make an assessment. The outlook for people with dementia varies. Age at diagnosis and response to treatment affect how the condition progresses. However, everyone is different. Some people with dementia survive 20 years or more after diagnosis. Living with dementia in the later stages It may be helpful for a person with dementia to be involved in decisions about their care before they become unable to communicate their wishes. Advanced care planning allows an individual with dementia to state what they want and do not want, such as living in a nursing home or being cared for at home. Living with late-stage dementia can often be challenging for patients and caregivers. As symptoms progress, more care is required. Strategies that may help someone with late-stage dementia include techniques to jog memory, such as visual clues or notes. Assistive technology devices include communications aids, automatic shutoff devices, and computerized recall devices. Caregivers should create an environment that is calm and safe. It is important to identify and correct safety concerns. This includes removing tripping hazards and making sure rooms are easy to get around. Caregivers should also ensure that medication is taken correctly, and that nutritional needs are met. Late-stage dementia can also be a difficult time for caregivers. Having a strong support system and allowing time to recharge is essential.

4: Alzheimer Disease Biomarkers Expose Individuals to Long-Term Care Insurance Denial

The U.S. health care system lacks the capacity to rapidly move a treatment for Alzheimer's disease from approval into wide clinical use, a shortcoming that could leave millions of people without access to transformative care if such a breakthrough occurs, according to a new RAND Corporation study.

They could also represent a treatable condition, such as a medication side effect or depression. Fatigue, discouragement, and forgetfulness overwhelmed him. He was taking too much time to complete his paperwork and other tasks that had always been easy. Each day he felt more concerned, though he tried to protect those around him by covering up his worries and mistakes. He remained careful about his general health and took his blood pressure medication every day. His wife, aware of his distress, urged him to get help. But where should he start? Warning signs of cognitive decline, which include symptoms like Mr. They can represent treatable conditions such as adverse medication effects, substance use, sleep problems, metabolic disorders, or depression. They can also be the early signs of AD or another progressive cognitive disorder. Primary care doctors and nurses are likely to know which initial questions to ask and which screening tests to do. Depending on the symptoms, they may do a physical examination, draw blood, order imaging studies, and suggest consultation. Consultation with one of the following specialized professionals, often at the recommendation of a primary care clinician, can be valuable. This is especially true when dealing with a more complicated situation such as a person whose age is young, whose cognitive symptoms are unusual or confusing, whose medical or psychiatric histories are complex, or whose behavioral problems are making it difficult to care for them. Who are the Specialists? The most common specialists consulted for someone with memory or other cognitive symptoms include the following: Geriatrician Geriatricians are physicians skilled in assessing and managing the medical problems that affect older adults. They may work as primary care clinicians or as specialists. Neurologist Neurologists are specialists in the diseases of the nervous system. Neurosurgeons are not the same as neurologists. They are experts in operating on the nervous system and are generally consulted after a potential surgical need has been identified. Clinical trials, which may involve testing new medications or diagnostic tools for dementia, are often run by a neurologist or a psychiatrist. Psychiatrist Psychiatrists specialize in the assessment and treatment of mental disorders. Not all psychiatrists are expert evaluators of cognitive disorders, but geriatric psychiatrists specialize in the emotional and behavioral conditions of older adults. Some geriatric psychiatrists and nurse clinical specialists specialize in dementia care, especially in the evaluation and management of behavioral symptoms of dementia such as mood changes, emotional outbursts, agitation, hallucinations or delusions, impulsivity, aggression, and inappropriate behavior. Psychologist Psychologists are trained to provide various kinds of assessment and psychosocial treatments. Referral to a psychologist may be made for psychotherapy, including caregiver support. Talk therapy can help a person and a caregiving system adjust to the diagnosis of dementia and to address the practical concerns, relationship stresses, and emotional reactions that can occur. Neuropsychologist Many psychologists perform comprehensive evaluations using reliable and standardized tests, and neuropsychologists are the psychologists who are specially trained to evaluate cognitive disorders. They are particularly valuable in assessing the severity of memory loss or other symptoms, helping to figure out the cause of the symptoms, measuring progress or decline over time, identifying areas of strength that can be reinforced, and designing a non-medication treatment approach. They can be valuable members of a caregiving team because they can assess what social supports are needed in order to cope effectively with present stresses and plan for the future. He was evaluated by his primary care physician PCP , who did a cognitive screening examination and identified Mr. This PCP was very experienced in the care of older adults, so she did not consider it necessary to get input from a geriatrician. Blood tests and neuroimaging tests were normal. This was very upsetting news for Mr. Thorne and his wife, and the PCP referred the couple to a geriatric psychiatrist to provide further information about dementia and supportive counseling. A psychiatrist rather than psychologist was chosen in this case, because the PCP suspected Mrs. Thorne might require antidepressant treatment. The psychiatrist, over several sessions, worked with the couple to facilitate their

communication and help them adjust to this stressful information about Mr. Thorne for depression and a decision was made to defer medication treatment for her symptoms, which seemed to be a temporary adjustment. He discussed the pros and cons of currently available AD medications for Mr. Thorne and gave the Thornes information regarding clinical trials that might be appropriate for Mr. The psychiatrist then referred them to a geriatric care manager who assisted them in planning for a future when additional supports might become necessary regarding financial planning, residential considerations, transportation, and advance care planning.

5: Is the definition of Alzheimer's disease changing? - Mayo Clinic

Brain changes associated with Alzheimer's disease lead to growing trouble with: Memory. Everyone has occasional memory lapses. It's normal to lose track of where you put your keys or forget the name of an acquaintance. But the memory loss associated with Alzheimer's disease persists and worsens, affecting your ability to function at work and at home.

There is no universally agreed upon staging system, so healthcare providers may use the one that they are most familiar with. Or your doctor may identify biomarkers that indicate your risk. But there will be no noticeable symptoms during the first stage, which can last for years or decades. Someone in this stage is fully independent. They may not even know they have the disease. Memory troubles are still very mild and may not be apparent to friends and family. While the entire stage lasts about seven years, the symptoms will slowly become clearer over a period of two to four years. Only people close to someone in this stage may notice the signs. Work quality will decline, and they may have trouble learning new skills. Other examples of stage 3 signs include: They may experience mild to moderate anxiety and denial. You or your loved one will have more trouble with complex but everyday tasks. Mood changes such as withdrawal and denial are more evident. Decreased emotional response is also frequent, especially in a challenging situation. New signs of decline that appear in stage 4 may include: But they may ask for help with other tasks such as writing checks, ordering food, and buying groceries. People in this stage will remember their own names and close family members, but major events, weather conditions, or their current address can be difficult to recall. At first, some people will forget to flush or throw tissue paper away. By this stage, memory is much worse, especially around current news and life events. Counting backward from 10 will be difficult. Your loved one may also confuse family members with other people and display personality changes.

6: What is Alzheimer's Disease? | CDC

The incidence of AD has been directly linked to a high percentage of individuals over 65 years of age, with up to 55% of people over 65 years of age being affected by the disease.³ This has obvious implications for the already over stretched health care system in many Asian counties.

Loss of memory is the usual first symptom. As the disease progresses, the loss of reasoning ability, language, decision-making ability, judgment, and other critical skills make navigating day-to-day living impossible without help from others, most often a family member or friend. Sometimes, but not always, difficult changes in personality and behavior occur. This does not mean that there will no longer be times of joy, shared laughter, and companionship. AD often develops gradually, offering time to adjust to the diagnosis, plan ahead, and spend quality time together. Dementia can be caused by many different medical conditions, such as a severe head injury or major stroke. Although the cause and progression of AD are not fully understood, increasing evidence shows that the first changes in the brain happen as much as 15 years before symptoms of dementia are exhibited by the person with AD. Certain kinds of brain scans can detect these changes. A number of non-medical, lifestyle practices are recommended for possible prevention, a healthy way to manage the disease, and general age-related well-being. There is evidence, but not definitively documented proof, that mental stimulation brain games, exercise like walking, swimming, yoga, social activities, and a healthy diet fruit, vegetables, and foods high in antioxidants may help. Given what we know about stroke prevention, maintaining healthy blood pressure, avoiding diabetes or managing it well, keeping cholesterol down, and not smoking are four key things you can do to lower your risk. This disease can appear as young as age 30, but is typically diagnosed after age 60, and risk of having the disease increases with age. The genetics of AD are complex, and knowledge is changing rapidly. Except for a small percent of families where a single gene causes the disease, having a family member with AD increases your risk only moderately. Symptoms People with AD may show symptoms of the disease three to five years before diagnosis. Early problems are often seen as normal changes due to aging, and only in retrospect do caregivers see that symptoms have been occurring for several years. Although on average, individuals survive four to eight years once diagnosed, living for 20 years is not all that unusual. For ease in understanding the changes that occur as the disease progresses, AD is generally divided into three stages: However, the development of symptoms in an individual will differ from person to person, as will the progression of symptoms. The doctor first needs to establish that the memory loss is abnormal and that the pattern of symptoms fits AD. This sometimes requires specialized memory testing. The doctor then needs to rule out other illnesses that can cause the same symptoms. For example, similar symptoms can be caused by depression, malnutrition, vitamin deficiency, thyroid and other metabolic disorders, infections, side effects of medications, drug and alcohol abuse, or other conditions. If the symptoms are typical of AD and no other cause is found, the diagnosis is made. In the hands of a skilled doctor, this diagnosis is very accurate. This approach can help the doctor determine whether further testing is needed. This examination will likely include a thorough medical evaluation and history, blood tests, and brain scans MRI or PET, followed by extensive neurological and neuropsychological assessments. A dementia evaluation should include interviews with family members or others who have close contact with the person being evaluated. Biomarkers are abnormal findings in blood, or cerebrospinal fluid CSF, or on brain scans that are markers of AD. Strong evidence suggests that special tests of the CSF may be useful diagnostically. As knowledge advances, these tests may come into clinical use. Even now, however, it is clear that they will not be good enough to diagnose AD on their own. The diagnosis will still depend on a skilled and thorough evaluation. Three main drugs, donepezil Aricept, rivastigmine Exelon and galantamine Reminyl, have proved beneficial in improving memory, with limited side effects, usually gastrointestinal upset. Exelon comes in a patch form, which is helpful for people who have trouble swallowing pills. Unfortunately, these drugs are not effective for everyone, and their effectiveness is limited to the early and middle stages of AD. Another drug, memantine HCl Namenda also prescribed to help delay the progression of AD, is often used in combination with the above drugs. A doctor may also prescribe medications to help reduce agitation, anxiety, and

unpredictable behavior, as well as to improve sleeping patterns and treat depression. New medications are developed and tested regularly. People interested in participating in clinical trials should discuss the pros and cons with their physicians and families. Regular care from a physician is important. Major, sudden changes in mental status can be the main symptom of important treatable conditions such as a urinary tract infection UTI, pneumonia, or even a bone fracture. If the physician knows the patient, he or she can quickly recognize a change in mental status. But if they are presented with a demented patient that they have not seen in years, it can be extremely difficult to know whether anything has changed and the proper workup may not be initiated. An effective treatment will address the needs of the entire family. Caregivers must focus on their own needs, take time for their own health, and get support and respite from caregiving regularly to be able to sustain their well-being during this caregiving journey. Absolutely the easiest thing for someone to say and the hardest thing to accept is the advice to take care of yourself as a caregiver. Research shows that caregivers experience lower stress and better health when they learn skills through caregiver training and participate in a support group s online or in person. Participation in these groups can allow caregivers to care for their loved one at home longer. Or perhaps there has been a sudden change in their health. Now it is time to take action, and take stock of the people, services, and information that will help you provide care. The earlier you get support, the better. The resources listed at the end of this fact sheet will help you locate local training classes and support groups. The role of the caregiver changes over time as the needs of the person with AD change. The following table offers a summary of the stages of AD, what kinds of behaviors to expect, and caregiving information and recommendations related to each stage of the disease. The more you know about AD, the easier it will be for you as a caregiver. Finding other caregivers to talk to can also be a great way to learn about and make sense of your own experience. One of the most difficult things to learn is to differentiate between the disease and your loved one. A diagnosis of AD can be a heart-wrenching experience for both the person diagnosed and the caregiver. Trying to convince them otherwise is fruitless and frustrating for the caregiver. The caregiver needs to get appropriate emotional support through counseling, a support group, or other family members. The goal is to establish a system of emotional support that will grow and change with you as your caregiving role and the emotional challenges change. Depression is common in caregivers of people with AD and should be addressed. As the disease progresses, it will be harder for the person with AD to fulfill the roles they have typically played in the family. For example, if he or she was the only driver in the family, it will be important for family members to find alternative means of transportation e. If the person with AD customarily prepared all of the meals, now is the time for the caregiver to begin learning how to cook. If the person with AD was in charge of household finances, someone else will need to assume this role. Focusing on these issues early will allow the person with AD to help the caregiver prepare for the future. AD can be a costly disease. It is important to begin mapping out strategies for meeting the increasing financial demands placed on the family as the disease progresses. Financial planning should include reviewing your insurance coverage, e. Be aware that Medicare does not pay for long-term care or custodial care. Medicaid, the safety net for those living on a limited income, does provide coverage for those who qualify. Health insurance counseling is available free to seniors. Legal documents should be completed as early as possible in the disease process, even prior to a diagnosis. Waiting too long may result in the person no longer being deemed capable of signing legal documents. The family may also lose access to bank accounts if a member is not co-named on the account s. Clear legal documentation can help prevent someone from attempting to take advantage of or lay claim to financial resources for their personal gain. Free and low-cost legal services are available to seniors. See the resource section of this fact sheet for organizations that can help with legal issues. Increased difficulty with verbal expression and comprehension, particularly when trying to name items Spatial problems e. Keeping the person with AD safe will become a priority. Both the person with AD and the caregiver will need help and support. Dealing with challenging behaviors: We often use intuition to help us decide what to do. Ten Real-life Strategies for Dementia Caregiving. People caring for loved ones with AD frequently feel isolated, and feelings of grief and loss surface as the person they are caring for changes see FCA fact sheet, Caregiving and Ambiguous Loss. Be sure to speak to your physician if you feel depressed or anxious. Respite care includes in-home help another family member, a neighbor, friend, hired caregiver, or volunteer caregiver , and

out-of-home help adult day care or a short stay in an assisted care facility. Creating a safe and comfortable environment is important. An occupational therapist or physical therapist can provide advice and help in making the home safer for both the caregiver and care recipient. The person with AD will need ongoing medical care both for AD and for any other health problems that might arise. Over time the caregiver will be depended upon to help provide the status update to medical staff. Make sure there is a release of information noted in the medical chart of the patient so that the physician can speak freely with you. It is important to develop a positive relationship with the physician s and other health care professionals. You will need them to understand your role as the caregiver, listen to your input, and work with you as a team member in providing appropriate medical care. The stress of caregiving can affect your health. Be sure to take care of yourself by getting regular medical care for yourself. If you need to be hospitalized or need time off from your caregiving duties, emergency respite care can be arranged.

7: Stages of dementia: How does the disease change over time?

Dementia is a degenerative condition that occurs with Alzheimer's, some vascular diseases, and others. It leads to a loss of thinking ability. Early symptoms include memory loss, but, in time, a.

The most common type of dementia. A progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment. Involves parts of the brain that control thought, memory, and language. The number of people living with the disease doubles every 5 years beyond age 65. This number is projected to nearly triple to 14 million people by 2050. There probably is not one single cause, but several factors that affect each person differently. Changes in the brain can begin years before the first symptoms appear. Memory problems are typically one of the first warning signs of cognitive loss. Memory loss that disrupts daily life, such as getting lost in a familiar place or repeating questions. Trouble handling money and paying bills. Difficulty completing familiar tasks at home, at work or at leisure. Decreased or poor judgment. Misplaces things and being unable to retrace steps to find them. Changes in mood, personality, or behavioral. It is important to consult a health care provider when you or someone you know has concerns about memory loss, thinking skills, or behavioral changes. Some causes for symptoms, such as depression and drug interactions, are reversible. However, they can be serious and should be identified and treated by a health care provider as soon as possible. Early and accurate diagnosis provides opportunities for you and your family to consider or review financial planning, develop advance directives, enroll in clinical trials, and anticipate care needs. Treatment addresses several different areas: Helping people maintain mental function. Slowing or delaying the symptoms of the disease. Caregiving can have positive aspects for the caregiver as well as the person being cared for. It may bring personal fulfillment to the caregiver, such as satisfaction from helping a family member or friend, and lead to the development of new skills and improved family relationships. Each day brings new challenges as the caregiver copes with changing levels of ability and new patterns of behavior. You can find more information about caregiving here. The 5th leading cause of death among adults aged 65 years or older. This work supports The Healthy Brain Initiative: The curriculum is available free of charge and consists of four modules that are designed to be used individually or as a whole each with slides and a faculty guide.

8: Dementia Care System Redesign | Wisconsin Department of Health Services

From family members to physicians to outpatient staff, managing Alzheimer's disease is a team effort. Alzheimer's patients require specific care, and many options are available to help family members and caregivers.

9: Alzheimer's Disease and Caregiving | Family Caregiver Alliance

Nearly 15 million Americans provide unpaid care to a person living with Alzheimer's disease or another dementia (Alzheimer's Association Facts & Figures). Dr. Alois Alzheimer, a German psychiatrist and neuropathologist, is credited with identifying the first published case of "presenile dementia" in 1906, a condition that is now called Alzheimer's disease.

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