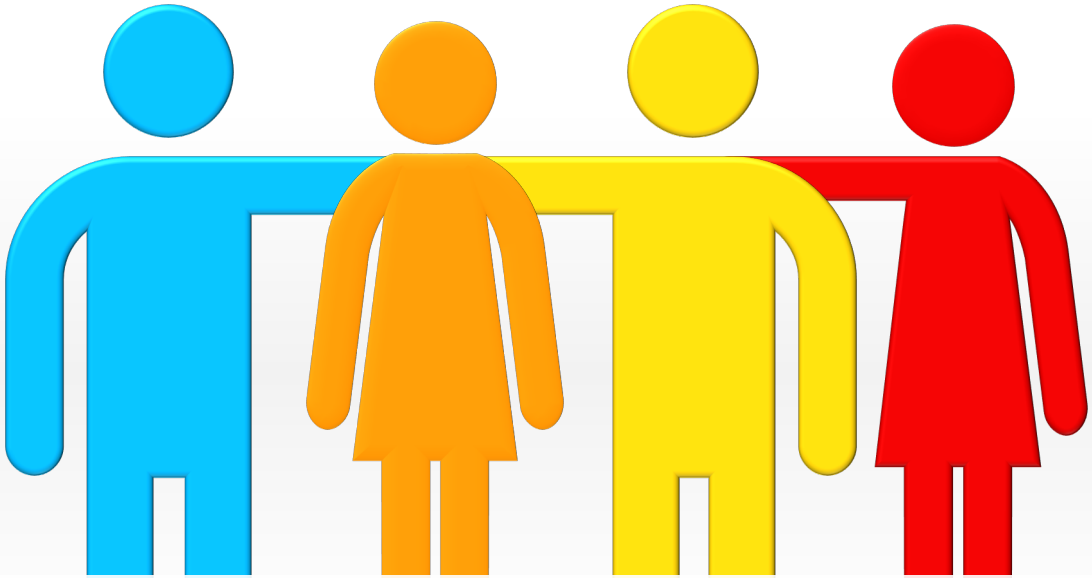

Geriatric Management in Primary Care: Meeting Complex Needs of Patients & Their Care Partners

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With support from Soo Borson, MD and Susan Foster Zdon, ARNP, MPH

OUR RECENT STUDY

Dementia Complexity: Understanding chronic care management needs of 100 recently hospitalized people living with dementia (PLWD) and their family/friend care partners (CP)

National Institutes of Health

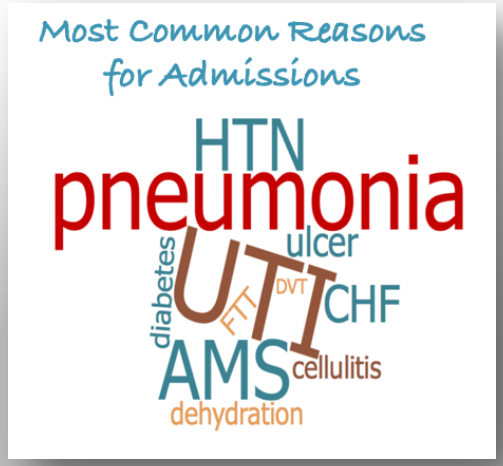
SCHOOL OF NURSING

CAMBIA health foundation

Study Findings

PLWD Medical Complexity

7 Medications
3 Difficult Behaviors
8 Chronic Conditions
8 Hospitalizations in past 12 months
7 Active problems on acute encounter
3 Active Amb. Care Sens. Cond (ACSC)
20% of CP failed cognitive screen



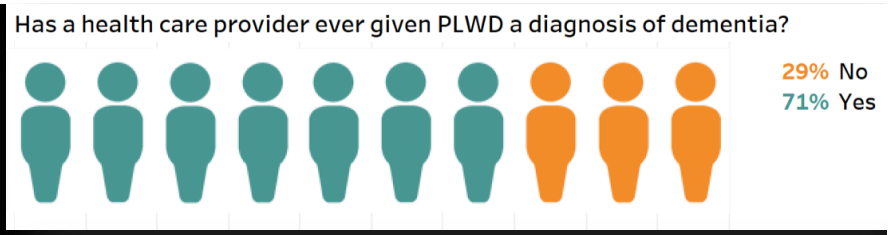
EMR Medications Missed by 80 CP

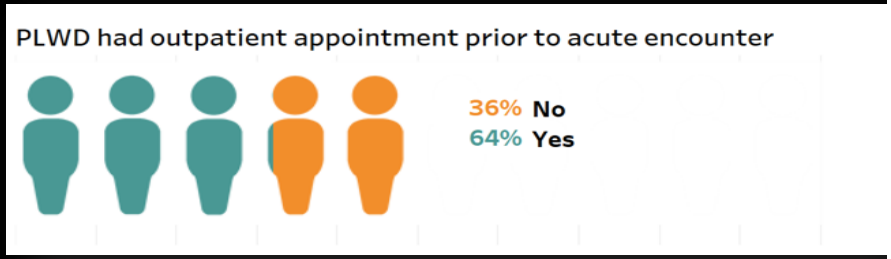
Medications Purpose Missed by 41 CP

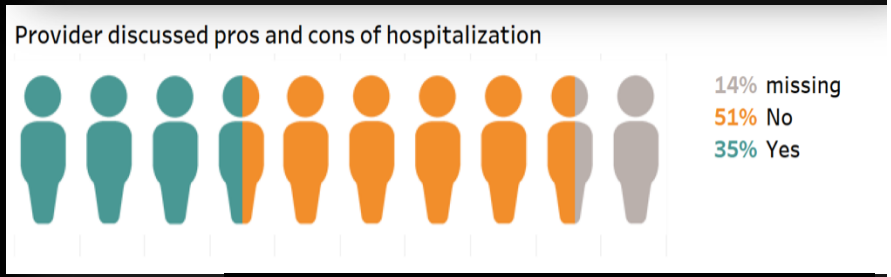
EMR Chronic Conditions Missed by 89 CP

Sadak, Ishado, Borson et al., under review

Study Findings







Sadak, Ishado, Borson et al., under review

Geriatric Multimorbidity

- 50% of older adults have at least two chronic conditions that require management
- **Most prevalent:**
  - Depression
  - Cardiovascular disease
  - Dementia
  - Hypertension
  - Arthritis
  - Diabetes
- **Multimorbidity is associated with**:
  - Poor health outcomes
  - Increased healthcare utilization
  - Disability, institutionalization and mortality

Chronic medical conditions + depression = most disabling

Associations between prevalent multimorbidity combinations and prospective disability and self-rated health among older adults in Europe. BMC Geriatrics. Sheridan et al., 2019

Multimorbidity combinations and disability in Older adults. J Gerontol Ser A Biol Med Sci. Quiñones et al., 2016

Polypharmacy & Geriatric Multimorbidity

- 51% of older adults take 11+ prescriptions
  - Potentially inappropriate prescribing increases by 10% with each additional medication

- **Medication related problems are more frequent in people with:**
  - Dementia
  - Depression
  - Congestive heart failure (CHF)
  - End-stage renal disease
  - Respiratory conditions
  - Hypertension
  - Diabetes

- **Polypharmacy increases**:
  - Adverse drug reactions
  - Healthcare utilization
  - Morbidity
  - Mortality

Associations Between Chronic Disease, Polypharmacy, and Medication-Related Problems Among Medicare Beneficiaries. J Managed Care. Almadovar et al., 2019

Depression

CHF

OBJECTIVES

Organizing Complexity: Five Domains of Health

Physical

Care Partner

Cognitive

Psychological

Social/Financial

5-part model is based on evidence that every domain is related to meaningful clinical outcomes

Adapted from Lessig, et al., 2006; Borson & Chodosh, 2014

PLWD are often medically complicated

Meet Mr. M
And his
family

Case: primary care follow-up after a hospitalization for exacerbated heart failure

Patient. Mr. M, a 70-year-old, Asian American man

- He is new to your practice
- Previous PCP retired
- Mr. M came in with his wife of 55 years and their two adult daughters
- M family moved to the US when children were young. Both parents speak some English

History

- Mr. M was hospitalized for 15 days with CHF exacerbation
- This was his 3rd CHF related hospitalization in the past 12 months

Physical Health Domain

Current diagnoses:

- HTN, CHF, Peripheral Vascular Disease, Osteoporosis

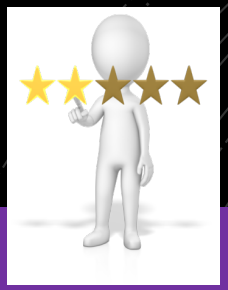
Exam:

- Patient has 1 + pitting ankle edema
- Mild SOB
- 5lb weight gain since hospital discharge 10 days ago
- BP 180/90

PHYSICAL HEALTH

Evaluate:

- Medications
- Life-style factors
- Ability to manage health conditions
  - Does he understand his conditions and treatment recommendations?
  - Can he self-manage?
  - Does he adhere to prescribed treatment?
  - Can CP assist?
  - How well does CP understand treatment recommendations?



Care Partner Domain

When asked about events prior to recent hospitalization Mrs. M reported:

- Mr. M looked unwell for a few days but said he felt fine
- When he started to have difficulty breathing, she called her daughters
- One daughter left work, came over and called 911
- PCP was not contacted when Mr. M started to “look unwell” because he didn’t have one
- Mrs. M said that she is not concerned about her husband’s hospitalizations because he “gets good help” and she gets a break

Per family interview:

Wife administers Mr. M's medications and helps to check his blood pressure (BP)

- She does not know that he has CHF, does not understand symptoms of exacerbation, and does not recognize CHF medications
- She knows that he has HTN but can not name medications prescribed for this condition or identify an expected range for normal BP

Daughters help with driving, meals and cleaning but have not been involved with Mr. M's medical management because their father is very private and proud of his independence

- They are concerned about father's recent acute physical decompensation and mom's sadness, stress, difficulty concentrating and difficulty managing Mr. M's forgetfulness & moods

CARE PARTNER

Mrs. M & her daughters:

- Need teaching about Mr. M's chronic conditions, medications and treatment recommendations
- Evaluate Mrs. M's ability to read/recognize medication names on the bottles

Mrs. M may benefit from:

- Referral to her PCP for evaluation of cognition, stress and depression
- Regular assistance from her daughters with Mr. M's medical management
- Respite
- Caregiver support group

Cognitive Health Domain

History (reported by family members):

- For several years Mr. M. has been forgetful but robust and active until about two years ago when he gradually stopped engaging in activities and socializing, and started to smoke more than usual
- He stopped gardening, walking and playing chess with the neighbor (these used to be his favorite activities)
- Mr. M gradually became very moody and irritable
- Mrs. M and her daughters report that Mr. M has never received a diagnosis of dementia
- Cognitive issues were not identified/addressed during hospitalizations

Mr. M

Denies forgetfulness and difficulty concentrating but does not recall a recent hospitalization and has difficulty finding words

COGNITIVE HEALTH

- **Diagnose**
- **Stage**
- **Discuss prognosis**
- **Discuss therapeutics**

Dementia must be the organizing principle of care

Diagnosis and staging

https://actonalz.org/provider-practice-tools

https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/AD/DAC%20Screening%20Position%20Paper.pdf

https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/AD/DAC-Clinical%20Provider%20Practice%20Tool.pdf

Treatment algorithm

https://content.iospress.com/articles/journal-of-alzheimers-disease/jad180903

Guidance and reimbursement for dementia care planning

https://www.alz.org/professionals/health-systems-clinicians/care-planning

Aligning goals of care with patient's/family goals of life

https://dementia-directive.org

Important to detect delirium comorbid with dementia and to offer early interventions

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5840908/

Psychological Health Domain

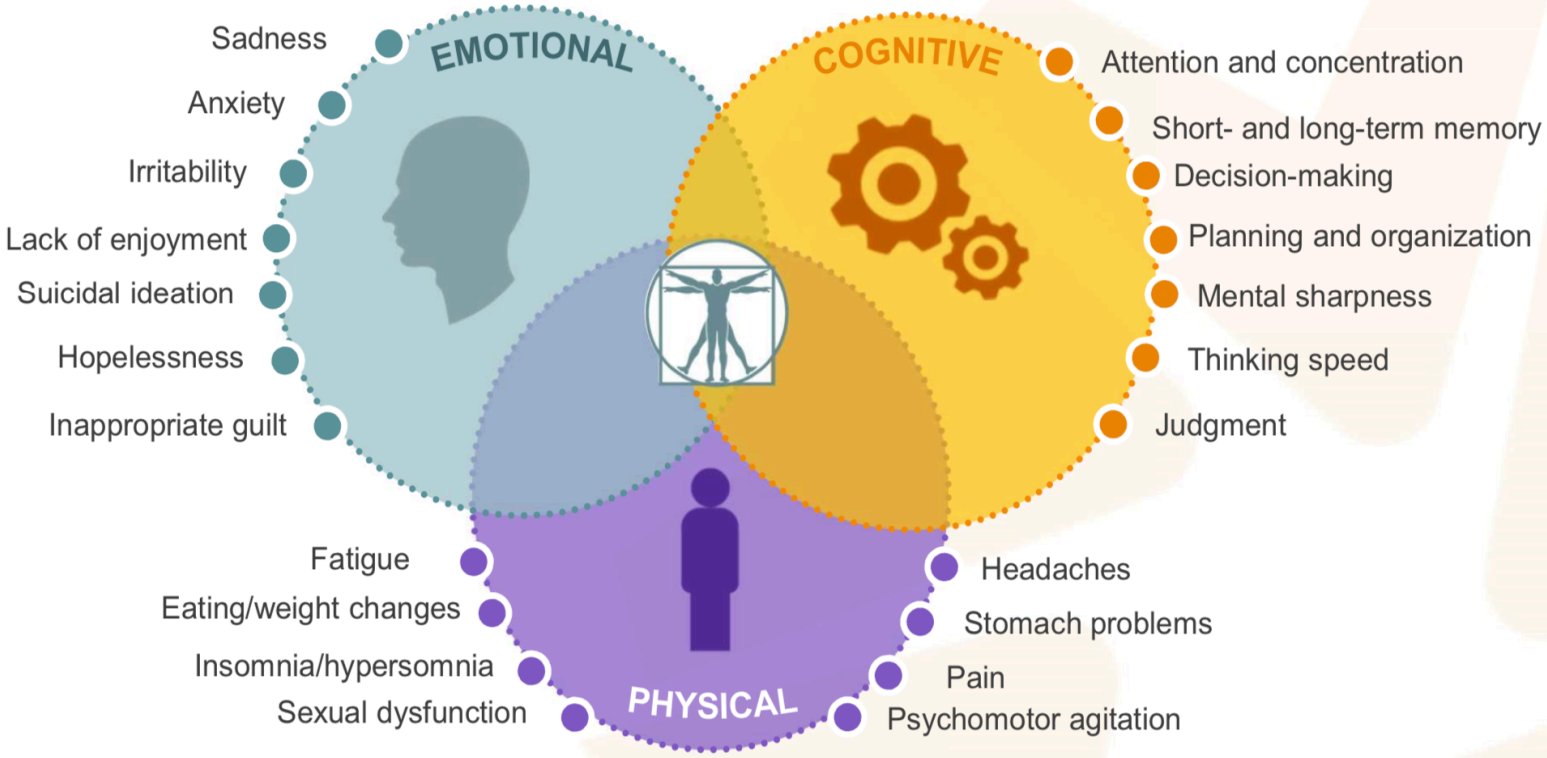
History (reported by family members):

- Mr. M worries that people are lying to him and stealing from the family
- Sometimes he hears people talking when no one is in the room and believes that he needs to find them and make them leave. This is distressing for him and his wife
- Mental health issues were not detected or addressed during hospitalizations

Mr. M

- Reports feeling fine, denies hallucinations
- Confirms being disinterested in hobbies and activities
- Says people are stealing from him
- Denies suicidal ideation
- Denies depression and anxiety but appears sad and irritable

MDD Has 3 Sets of Symptom Domains – Emotional, Physical, and Cognitive



MDD = major depressive disorder.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* Arlington, VA: American Psychiatric Association; 2013. Marazziti D, et al. *Eur J Pharmacol*. 2010;626(1):83-86. Hammar A, et al. *Front Hum Neurosci*. 2009;3:26. Fehnel SE, et al. *CNS Spectr*. 2016;21(1):43-52.

Depression & Dementia

Among depressed older patients ~52% have first episode at age 60+

People with late life onset depression are more likely to:

- Have vascular risk factors (e.g. HTN, diabetes) or vascular disease
- Neuroimaging changes, e.g. white matter hyperintensities, particularly in frontal-striatal and frontal-limbic brain pathways

- 30-40% of PLWD have depression or depressive symptoms
- Undiagnosed and untreated depression is associated with increased morbidity, accelerated cognitive decline and mortality

Diagnosing and Treating Depression in Patients with Alzheimer's Disease. Anna D. Burke, Danielle Goldfarb, Padmaja Bollam & Sehar Khokher. Neurology and Therapy volume 8, pages325–350(2019); https://link.springer.com/article/10.1007/s40120-019-00148-5

Symptoms and Presentation of Depression May Be Atypical

- Denial of depressed mood
- May present with physical symptoms: insomnia, anorexia, treatment-resistant pain, fatigue, gastrointestinal symptoms
- May present with behavioral changes: irritability, agitation, increased social isolation and dependency
- False beliefs about normal aging, and stigma, may prevent help-seeking
- Dementia may interfere with accurate history and symptom reports
- Assessment should incorporate CP input (history; CSDD, or PHQ-9 interview with with CP)

  E.g. Cornell Scale for Depression in Dementia

  - https://www.psychcongress.com/cornell-scale-depression-dementia-csdd

Table 3 Depression scales used in geriatric psychiatry

From: Diagnosing and Treating Depression in Patients with Alzheimer's Disease

Scales	Description
Geriatric Depression Scale (GDS)	Self-report questionnaire with "yes" or "no" responses. Different versions are available, with the number of questions ranging from 30 to 4. The 5-item GDS is reported to be as effective as the 15-item GDS for the screening of depression in cognitively intact older individuals
Cornell Scale for Depression in Dementia (CSDD)	Developed specifically for the assessment of depression in dementia. It is a 19-item comprehensive interview of both patient and informant and includes the clinician's impression Assesses signs and symptoms during the week preceding the interview
NIMH-dAD	The NIMH Provisional Diagnostic Criteria for Depression in Alzheimer's Disease, a provisional set of diagnostic criteria for depression in AD, developed in 2001 in order to better reflect the clinical features of depression in AD
Center for Epidemiologic Studies Depression Scale (CES-D), NIMH	A 20-item self-report questionnaire on symptom frequency during the past week. Responses range from rarely or none to most or all the time
Neuropsychiatric Inventory (NPI)	Useful to assess 10 behavioral areas and 2 neurovegetative areas. Assessment is based on informant (caregiver) observations. Scores for the areas reveals frequency and severity and caregiver distress
Hamilton Rating Scale of Depression (HAM-D)	Gold standard of observer-rated depression rating scales. Requires training to administer. Is helpful in assessing the severity of depression
Montgomery-Asberg Depression Rating Scale (MADRS)	Administered by a trained interviewer. Helpful to measure progress. Useful for assessment of depression in individuals with physical illness
Beck Depression Inventory (BDI)	A 21-item, self-report, multiple choice inventory. Revised version is BDI-II. Helps to assess severity of depression
Patient Health Questionnaire (PHQ)	PHQ-9—self-report questionnaire: helps screen, diagnose, monitor, and measure severity of depression. PHQ-2—"first step" approach: enhances routine enquiry
Zung Self-Rating Depression Scale (SDS)	A 20-item self-report questionnaire to screen affective, psychological, and somatic symptoms associated with depression

National Institute of Mental Health Diagnostic Criteria for Depression in Dementia

A. Three (or more) of the following symptoms must be present during the same 2-week period and represent a change from previous functioning. At least one of the symptoms must either be (1) depressed mood or (2) decreased positive affect or pleasure

1. Clinically significant depressed mood
2. Decreased positive affect or pleasure in response to social contacts and usual activities
3. Social isolation or withdrawal
4. Disruption in appetite
5. Disruption in sleep
6. Psychomotor changes
7. Irritability
8. Fatigue or loss of energy
9. Feelings of worthlessness, hopelessness, or excessive or inappropriate guilt
10. Recurrent thoughts of death, suicidal ideation, plan or attempt

B. All criteria are met for dementia of the Alzheimer type (DSM-IV)

C. The symptoms cause clinically significant distress or disruption in functioning

D. The symptoms do not occur exclusively in the course of delirium

E. The symptoms are not due to the direct physiological effects of a substance

F. The symptoms are not better accounted for by other conditions such as major depressive disorder, bipolar disorder, bereavement, schizophrenia, schizoaffective disorder, psychosis of Alzheimer disease, anxiety disorders, or substance-related disorders

https://pubmed.ncbi.nlm.nih.gov/28453472/

2018 Recommendations of the National Institute for Health and Care Excellence for Management of Depression in Dementia

First line nonpharmacological therapies include:

- For Mild Cognitive Impairment (MCI) and early stages of dementia
  - Emotion-oriented therapies (validation, reminiscence, reality, and simulated-presence therapy)
  - Brief psychotherapies
  - Modified cognitive-behavioral strategies
- For moderate to severe dementia
  - Behavioral therapies (e.g. Behavioral Reinforcement)
  - Sensory-stimulation (music therapy, art therapy, pet therapy, aromatherapy, activity therapies, and multisensory approaches)
- All stages
  - Exercise
  - Reduction of cardiovascular risk factors
  - Interventions that are delivered by and include care partners

Antidepressants should not be offered as first line therapy unless indicated for recurrence of a preexisting depressive disorder

Diagnosing and Treating Depression in Patients with Alzheimer's Disease. Anna D. Burke, Danielle Goldfarb, Padmaja Bollam & Sehar Khokher. Neurology and Therapy volume 8, pages325–350(2019); https://link.springer.com/article/10.1007/s40120-019-00148-5

Depression in Dementia. Pharmacological Interventions

- Consider medications when non-pharmacological interventions were tried but not sufficient
- It is important to differentiate depression from apathy for which medications are usually not effective
- Medications have strongest efficacy for agitation and anxiety but not everyone responds
- Work Group on Alzheimer's Disease and Other Dementias of the American Psychiatric Association recommend selective serotonin reuptake inhibitors (SSRIs) as the first pharmacological treatment for depression in dementia
  - SSRIs tend to be better tolerated and have fewer serious adverse effects
  - If patients cannot tolerate higher dosages needed for remission, trials of alternative antidepressants such as bupropion, venlafaxine, and mirtazapine may be considered

Rabins PV, Blacker D, Rovner BW, et al. American Psychiatric Association practice guideline for the treatment of patients with Alzheimer's disease and other dementias, second edition. Am J Psychiatry. 2007;164(12 Suppl):5–56

Depression in Dementia. Treatment Effectiveness

Systematic literature reviews report positive effects of sertraline, fluoxetine, citalopram, & trazodone

- Sertraline demonstrated best efficacy
  - Doses of 50–100 mg QD considered safe and appropriate

- Buspirone & mirtazapine may help agitation (case reports, small studies)
- Vortioxetine may improve depression & cognition
- Brexpiprazole augmentation may improve depression and social functioning
- Cognitive-enhancing medications (e.g. acetylcholinesterase inhibitors) do not treat depression

Diagnosing and Treating Depression in Patients with Alzheimer's Disease. Anna D. Burke, Danielle Goldfarb, Padmaja Bollam & Sehar Khokher. Neurology and Therapy volume 8, pages325–350(2019); https://link.springer.com/article/10.1007/s40120-019-00148-5

Adverse Effects of Antidepressants in Patients with Dementia

SSRIs

- Nausea and vomiting, agitation, anxiety, indigestion, diarrhea or constipation, dizziness, blurred vision, dry mouth, diaphoresis, loss of appetite and weight loss, insomnia or sedation, hyponatremia, headaches, GI bleeding, prolonged QTC, and sexual adverse effects
  - SSRI's have less marked anticholinergic and antiadrenergic properties, and therefore, may be less likely to cause confusion or falls then tricyclics
- Highest risk of prolonged QTC
  - Citalopram & escitalopram

Risk increases when combined with medications (e.g., cimetidine, omeprazole) that decrease their metabolism, and raise serum blood levels

Tricyclics

- Confusion
- Increased intraocular pressure
- Urinary retention
- Dry mouth, constipation
- Tachycardia
- Postural hypotension
- Dizziness
- Risk of falls
- Prolonged QTC

Trazodone

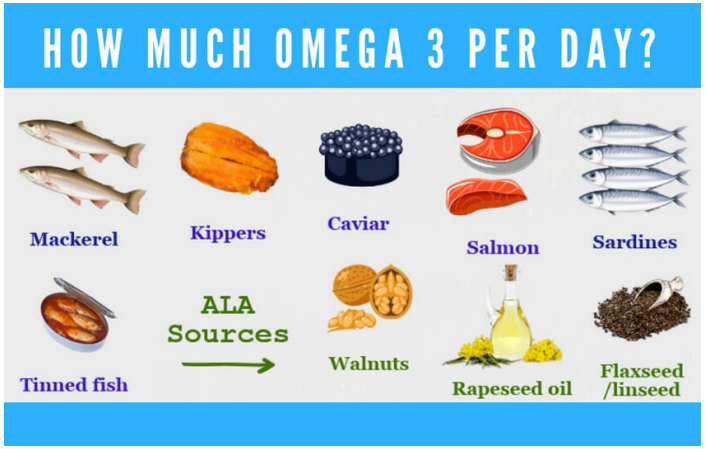
- Causes alpha-1 blockade
  - Hypotension at higher doses

Diagnosing and Treating Depression in Patients with Alzheimer's Disease. Anna D. Burke, Danielle Goldfarb, Padmaja Bollam & Sehar Khokher. Neurology and Therapy volume 8, pages325–350(2019); https://link.springer.com/article/10.1007/s40120-019-00148-5

Depression in Dementia: Using Antidepressants Safely

- Before you start:
  - Review potential for drug interactions between what you want to prescribe and the patient's other medicines and health risks
  - Check serum sodium and schedule re-check in 4-6 weeks (hyponatremia is a common side effect)
- Titrate doses slowly, monitor therapeutic and adverse effects and existing illnesses
  - Use the highest tolerated dose till remission is achieved
  - Do not continue an ineffective low dose
- Treat for 4–6 weeks at the optimum dose before changing
  - If no benefit after six weeks, make a new treatment plan

Depression in dementia. David Kitching. Aust Prescr. 2015 Dec; 38(6): 209–2011.



- Low levels of omega-3 fatty acid are associated with increased mortality in depressed HF patients
  - ~ 30% higher risk of mortality for every 0.1 unit of eicosatetraenoic acid reduction
- Omega-3 supplementation is associated with improvement in cognitive, depressive symptoms, social functioning and 6-min walk test
- Some evidence for higher efficacy of antidepressants in association with polyunsaturated fatty acids in depressed patients

Wei Jang et.all., JACC Heart Fail. 2018 Oct;6(10):833-843. Long-Chain Omega-3 Fatty Acid Supplements in Depressed Heart Failure Patients: Results of the OCEAN Trial

Depression and Cardiac Medications

β-Blockers

- Lipophilic (e.g., propranolol, metoprolol) – cross the blood-brain barrier easier than hydrophilic (e.g., atenolol)
  - β-Blockers as a class are not clearly associated with depression; there is the most evidence for a propranolol-depression link, but even this relationship is equivocal
  - Findings are not consistent. Most studies did not account for confounders (e.g., use of benzodiazepines, frequency of outpatient visits)
  - Systematic review of 35000 patients reported no association with increased depression for both lipophilic and hydrophilic agents
  - Some efficacy in reducing agitation and aggression in PLWD is observed

Lipid-lowering agents

- Low absolute cholesterol levels have been correlated with depression and suicide, but several large trials have not found increased depression and suicide rates associated with these drugs. Further research is needed

Other cardiac medications have not been consistently associated with a substantial increase in depression

Huffman & Stern. 2007. Dialogues in Clin Neurosci. Mar; 9 (1) 29-45

Late Life Depression With Psychotic Features

Psychotic features

- Delusions – False fixed beliefs
- Hallucinations – False sensory perceptions, usually auditory
- Often not reported by patients or CP, ask about them

Only medicate when patient and/or caregivers are significantly distressed by psychotic symptoms

- Only about half of PLWD who take antipsychotics benefit

Major side effects

- increased mortality and faster cognitive decline

- Antipsychotic augmentation of antidepressants
  - Risperidone 0.25 – 2.00 mg/day
  - Olanzapine [Zyprexa] 2.5 – 10 mg/day
  - Quetiapine [Seroquel] 50 – 200 mg/day
    - Recommended for psychosis and agitation
  - Aripiprazole [Abilify] 2-10 mg/day
    - Recommended for psychosis and vegetative symptoms
- If initial treatment fails, treatment of choice is ECT

Antipsychotics in Dementia

FDA issued warning, first in 2005 and again in subsequent years, for use of antipsychotics for PLWD

- Applies to antipsychotics as a class. Exact relationship and physiological mechanism of increased mortality are not well understood.

The American Psychiatric Association responded by stating publicly that there are times when treating the risky behaviors of dementia patients with antipsychotics is appropriate, “with the right precautions and under the right circumstances”

- They should not be used unless extreme behaviors do not improve with non-drug management strategies
- Despite common use in delirium, antipsychotics do not improve primary symptoms (confusion, fluctuation and disorientation) or shorten duration

Current federal administration has cut oversight and regulation in areas including pharmaceutical administration in nursing homes and memory care facilities, an effort named “Patients Over Paperwork.”

https://www.cms.gov/About-CMS/Story-Page/Patients-Over-Paperwork-fact-sheet.pdf

- Less oversight should not influence clinicians’ commitment to prescribing responsibly

Table 1

Side effect profiles of selected antipsychotic drugs

Adverse effects	AMI	ARI	CPZ	CLO	HAL	LUR	OLA	PAL	PER	QUE	RIS	SER	ZIP
Anticholinergic effects	0	0	++	+++	0	0	++	0	0/+	+/++	0	0	0
Acute parkinsonism	+	+	+	0	+++	+/++	0/+	++	++	0	++	0/+	+
Akathisia	+	++	+	+	+++	+/++	+	+	++	+	+	+	+/++
Tardive dyskinesia	0/+	0/+	++	0	++	0/+	0/+	0/+	++	0/+	0/+	0/+	0/+
Diabetes	0/+	0/+	+++	+++	0/+	0/+	+++	+	+	++	+	+	0/+
Weight gain	0/+	0/+	+++	+++	+	0/+	+++	++	++	++	++	++	0/+
Increased lipids	+	0/+	+++	++	0/+	0/+	+++	+	+	++	+	+	0/+
Sialorrhea	0	0	0	++	0	0	0	0	0	0	0	0	0
Neutropenia	0/+	0/+	0/+	+++	0/+	0/+	0/+	0/+	0/+	0/+	0/+	0/+	0/+
Orthostatic hypotension	0/+	0/+	++	++	0	0/+	+	+	+	++	+	++	0
Hyperprolactinemia	+++	0	+	+	++	+	+	+++	++	0	+++	+	+
Increased QTc interval	++	0/+	0/+	++	0+	0/+	0/+	+	+	+	+	++/+++	++
Sedation	0/+	0/+	++	+++	+	+/++	+/++	0/+	+	++ b	+	0/+	+
Seizures	0/+	0/+	0/+	++	0/+	0/+	0/+	0/+	0/+	0/+	0/+	0/+	0/+

Open in a separate window

AMI – amisulpride, ARI – aripiprazole, CPZ – chlorpromazine, CLO – clozapine, HAL – haloperidol, LUR – lurasidone, OLA – olanzapine, PAL – paliperidone, PER – perphenazine, QUE – quetiapine, RIS – risperidone, SER – sertindole, ZIP – ziprasidone, 0: none or equivocal, 0/+: minimal/rare, +: mild/sometimes occurs, ++: moderate/occurs frequently, +++: severe/occurs very often

Management of common adverse effects of antipsychotic medications

T. Scott Stroup and Neil Gray · World Psychiatry. 2018 Oct; 17(3): 341–356.

Table 3–7. Suggested schedule for monitoring adverse effects of antipsychotic treatment

	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Every 6 months	Annually	Every 5 years
Abnormal Involuntary Movement Scale	x	x	x			x		
Blood pressure and pulse (orthostatics)	x	x	x	x			x	
Electrocardiogram	x							
Fasting plasma glucose	x			x			x	
Fasting lipid profile	x			x				x
Liver function tests	x					x		
White blood cell count with differential	x	x				x		
Waist circumference	x						x	
Weight and height (body mass index calculation)	x	x	x	x	x			

PSYCHOLOGICAL HEALTH

- Mr. M has depression with psychotic features that is comorbid with dementia and CHF
- He needs a psychosocial care plan that helps him to feel engaged and supports his family
- Refer family members to community resources that will help them learn non-pharmacological behavioral and emotional support interventions
- Consider omega-3 supplementation
- Consider a trial of sertraline

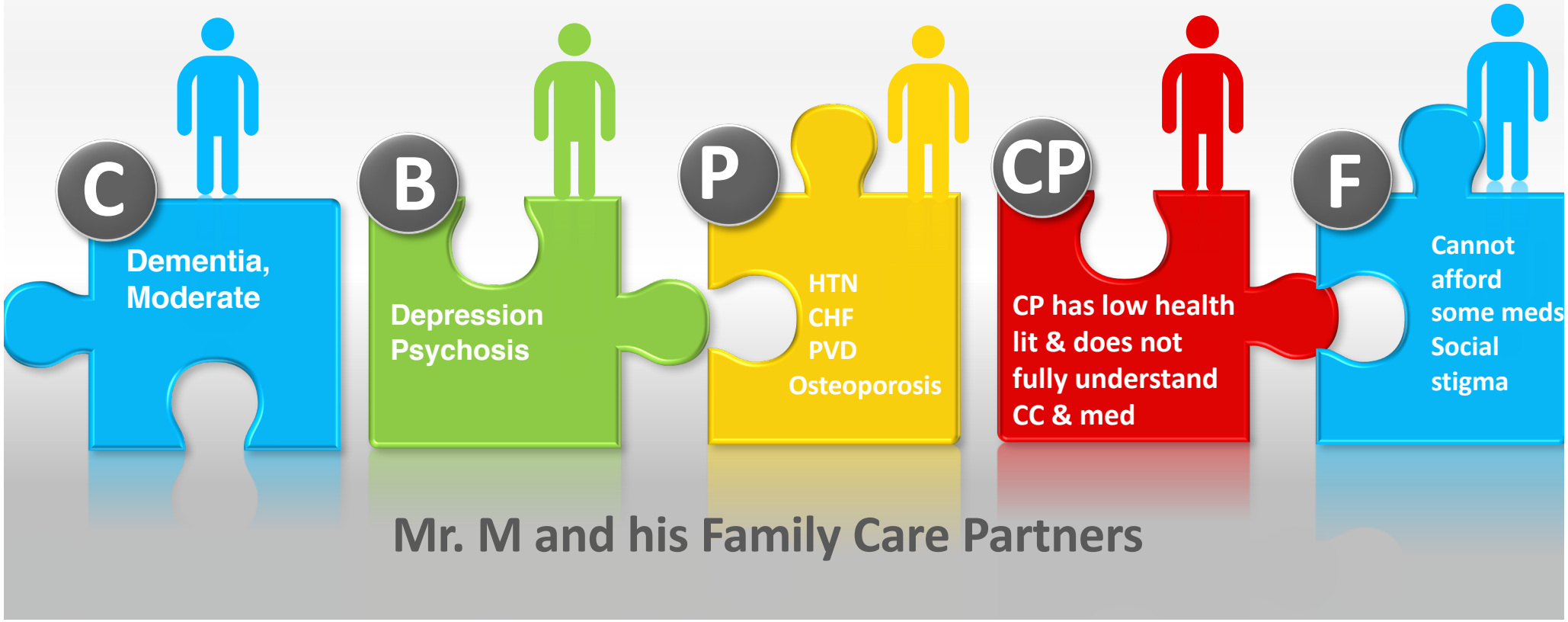
Social/Financial Health Domain

- Mrs. M reports that she is concerned because the co-pays for some of the currently prescribed medications are too high
- She is also very concerned about diagnoses of dementia and depression stating that in their culture they are associated with significant stigma and that she ”will not be able to tell anyone”
  - Depression is seen a weakness
  - Dementia is seen as shameful
- She is also worried about involving daughters in helping with medical management of their father’s health, because ”he would feel helpless and not have privacy”
- Does not want to burden daughters who “need to make their life in the new country”

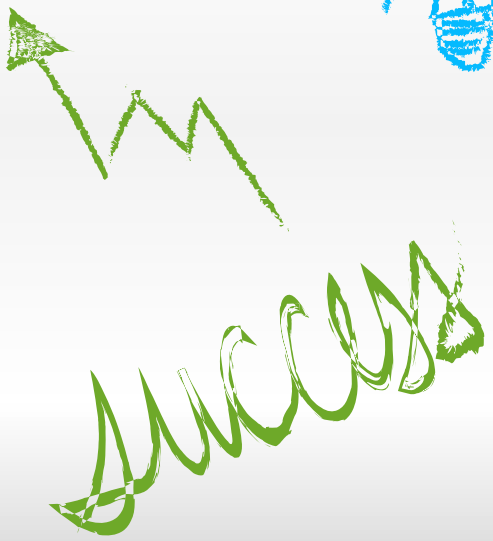
Social/Financial HEALTH

- Refer to the Alzheimer's Association 1-800# for culturally tailored support and referral to local recourses
- Evaluate prescribed medications and substitute high cost prescriptions
- Discuss with Mrs. M and her daughters the use of alternative terminology:
  - Sadness – in place of the term depression
  - Forgetfulness – in place of the term dementia and neurocognitive disorder
- Engaging a younger generation, when available may be helpful
- Providers need to be sensitive about issues of trust and reluctance to disclose symptoms/problems
  - Mrs. M may under-report her stress, burden and depression

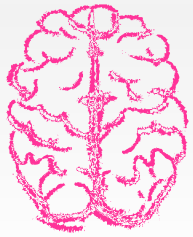
5 Domains of Health



Mr. M and his Family Care Partners



DPEN
UWSON
Dementia & Palliative Education Network



Opportunity for UW alums working as RNs
Queen Silvia Dementia Nursing Award
https://nursing.uw.edu/research/uwqsna/

- FREE Comprehensive Geriatric Assessment https://www.cgakit.com/cga---more
  - Geriatric Physical Exam
  - Geriatric Prescribing Guidelines and Medications Review
  - Geriatric Syndromes
    - Frailty, Falls, Incontinence, Pressure Ulcers, Sleep Disorders
  - Proactive Care
    - Personalized Care Planning
    - Nutrition
    - Exercises for older adults
  - Thorny Issues
    - Elder abuse assessment, Tough Conversations, Alcohol Assessment, Hoarding in late life, Driving
- STOPP/START
  - https://www.kssahsn.net/what-we-do/our-news/events/Past%20events%202017/2016%20Stopp%20Start%20Cumbria.pdf
- Psychiatric Medications Dosing for Elderly
  - Appropriate Use of Psychotropic Drugs in Nursing Homes. Am Fam Phys. Gurvich, 2000.
- WA Alzheimer's and Related Behaviors state plan
  - https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/AD/2016%20WA%20Alzheimer%27s%20State%20Plan%20-%20Core%20Report%20%20Appendix%20A.pdf
- WA State Bree Collaborative dementia recommendations for healthcare providers
  - http://www.breecollaborative.org/wp-content/uploads/Alzheimers-Dementia-Recommendations-Final-2017.pdf
- WA Dementia Action Collaborative
  - https://www.dshs.wa.gov/altsa/dementia-action-collaborative
- Tatiana's website that contains information for patients, care partners and clinicians
  - Tatianasadak.com