BRAIN HEALTH INTEGRATION INTO HEALTH CENTER SERVICES

Webinar 1: Early Detection of Dementia & Reducing Risk Factors

Wednesday, May 3rd 1-2pm ET
During today’s session:

• **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select “Everyone”! There will be Q&A and discussion at the end.

• **Resources:** If you have a tool or resource to share, let us know in the chat!
America’s Voice for Community Health Care
The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.
NACHC Quality Center

Cheryl Modica
Director, Quality Center

Cassie Lindholm
Deputy Director, Quality Center

Holly Nicholson
Manager, Instructional Design & Learning

www.nachc.org
Packaging and implementing evidence-based transformational strategies for safety-net providers

*Bringing science, knowledge, and innovation to practice*
Our Goal

Improved Health Center Performance through Systems Transformation

Quintuple Aim Goals

- Improved Health Outcomes
- Improved Patient Experience
- Improved Staff Experience
- Reduced Cost
- Equity
Brain Health Webinar Series

This 3-part webinar series is focused on the important role health centers play in dementia – early detection, reducing risk factors, care management, and effective partnerships.

Each webinar will offer health center-oriented action steps, and will feature subject matter experts in brain health, reimbursement, care management, and more!

**Wednesday, May 3rd 1-2pm ET**
Early Detection of Dementia & Reducing Risk Factors

**Wednesday, May 17th 1-2pm ET**
Care Management for Patients with Dementia & Leveraging Reimbursement Opportunities

**Wednesday, May 31st 1-2pm ET**
Health Center Partnerships & Community Linkages to care for Patients with Dementia
Agenda: Early Detection of Dementia & Reducing Risk Factors

Systems Approach to Primary Care and Value-Based Care Transformation
Cheryl Modica, PhD, MPH, BSN | NACHC
- The Value Transformation Framework and Elevate
- Systems approach to brain health, evidence-based care

Dementia: Early Detection and Reducing Risk Factors
Dr. Nicole Purcell, DO, MS | Alzheimer’s Association
- Why it is critical for health center care teams and providers to focus on dementia
- What can be done to identify and reduce risk factors

Dr. Soo Borson, MD | NYU BOLD Center
- How health centers and primary care providers can provide early detection

Dr. Barak Gaster, MD | University of Washington
- Reflections from the point of a primary care provider

Discussion/Q&A
The Value Transformation Framework (VTF) is an organizing framework to guide health center systems change:

- **Supports change** in many parts of the health center simultaneously
- **Organizes and distills evidence-based interventions** for discrete parts of the systems called ‘Change Areas’
- **Incorporates evidence, knowledge, tools and resources** relevant for action within different parts of the system, or Change Areas
- **Links health center performance to the Quintuple Aim**
The Value Transformation Framework

15 Change Areas organized by 3 Domains:

**Infrastructure:** the components, including health information systems, policies, and payment structures, that build the foundation for reliable, high-quality health care

**Care Delivery:** the processes and proven approaches used to provide care and services to individuals and target populations, such as evidence-based care and social drivers of health

**People:** the stakeholders who receive, provide, and lead care at the health center, as well as partners that support the goals of high-value care
Elevate National Learning Forum

Guided application of the Value Transformation Framework
Evidence-Based Care

DOMAINS

- INFRASTRUCTURE
  - Improvement Strategy
  - Health Information Technology (HIT)
  - Policy
  - Payment
  - Cost

- CARE DELIVERY
  - Population Health Management
  - Patient-Centered Medical Home
  - Evidence-Based Care
  - Care Coordination And Care Management
  - Social Drivers Of Health

- PEOPLE
  - Patients
  - Care Teams
  - Governance And Leadership
  - Workforce
  - Partnerships

RESOURCES

- Cancer Screening
- Diabetes
- Hypertension

Brain Health NEW!
Featured Expert:

Dr. Nicole Purcell, DO, MS
Senior Director, Clinical Practice

ALZHEIMER'S ASSOCIATION®
Dementia: A Clinical Perspective: Speaker Disclosure

• No relevant financial disclosures.
• Understand the epidemiology of dementia
• Explore the benefits of early detection and diagnosis
• Identify common risk factors for cognitive impairment
• Differentiate between normal and abnormal aging
• Differentiate between other dementia syndromes
Dementia is a Syndrome

- Dementia is a collection of symptoms related to cognitive decline
- Can include cognitive, behavioral and psychological symptoms
- Due to biological changes in the brain
- Alzheimer’s is most common cause
- Mixed dementia is very prevalent
- Some causes of cognitive decline are reversible and not truly dementia
More than 6 million Americans are living with Alzheimer's.
About 1 in 9 people ages 65 and older have Alzheimer’s disease.
Percentage of people with Alzheimer’s dementia increases with age. People younger than age 65 can develop Alzheimer’s, but it is much less common.
1 in 3 seniors dies with Alzheimer’s or another dementia.
Alzheimer's kills more people than breast cancer and prostate cancer combined.
Almost **two-thirds** of Americans with Alzheimer’s are women.

Older Black Americans are about **twice** as likely to have Alzheimer’s or other dementias as older White Americans.
Genetic factors do not account for the difference in racial groups

Social determinants of health may impact some or all of these risk factors
98% of primary care physicians feel it's important to diagnose MCI

96% of primary care physicians feel it's important to assess patients 60 and older for cognitive impairment

But report that they conduct assessments for just 48% of these patients.
Most frequently cited challenges when making an MCI diagnosis:

- Difficulty differentiating normal aging from MCI
- Difficulty interpreting patient reports of daily functioning
- Lack of specialists and facilities to perform diagnostic testing
- Patient reluctance to pursue follow-up testing
- PCP reluctance to diagnose a condition that has limited treatment options
• Nearly half of Americans (47%) worry about developing MCI in the future
• Asian (54%) and Hispanic (52%) Americans are more likely to worry than Native (47%), White (45%) and Black Americans (44%)
• A majority of Americans would want to know if they had Alzheimer’s disease early
**Benefits of Early Detection**

- Addressing modifiable risk factors may slow progression of dementia in those who have MCI due to Alzheimer's disease.
- Evaluation for other causes of cognitive impairment.
- Better management of comorbid conditions through medication adherence and compliance with care plans.
- Reducing anxiety about symptoms.
- Opportunity to participate in clinical trials.
- Opportunity to discuss treatments and new medications.
Benefits of Early Detection

Safety assessments
- Driving
- Home environment
- Elder abuse

Advanced care planning
- Identification of trusted individuals who can make decisions and advocate on the person’s behalf
- Participation in care and living decisions
- Address legal and financial matters
- Develop lasting relationships

Cost savings
- Patient
- Caregivers
- Health care system
## Modifiable Risk Factors

<table>
<thead>
<tr>
<th>WILL affect risk of cognitive decline and dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Education</td>
</tr>
<tr>
<td>✓ Traumatic Brain Injury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WILL affect risk of cognitive decline and MAY affect risk of dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Midlife Hypertension</td>
</tr>
<tr>
<td>✓ Physical Inactivity</td>
</tr>
<tr>
<td>✓ Midlife Obesity</td>
</tr>
<tr>
<td>✓ Diabetes</td>
</tr>
<tr>
<td>✓ Smoking</td>
</tr>
<tr>
<td>✓ Poor Sleep</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAY affect risk of cognitive decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Balanced Nutrition</td>
</tr>
<tr>
<td>✓ Cognitive Engagement</td>
</tr>
</tbody>
</table>
Others You May Hear About

Lower Level/Unclear Evidence:

• Hearing loss
• Air pollution
• Depression
• Hyperlipidemia
• Alcohol abuse
• Moderate alcohol use
• Social engagement
Unmodifiable Risk Factors for Cognitive Impairment

• Increasing age
  – Strongest risk factor
• Family history
  – Risk increases with the number of first-degree relatives, and to a lesser extent, second-degree relatives
• Genetics
  – Deterministic genes: <1% of all Alzheimer’s; 50/50 risk of AD
    • Dominantly inherited mutations in amyloid beta precursor protein (APP) gene, presenilin 1 (PSEN1) gene and presenilin 2 (PSEN2) gene
    • Trisomy in Down syndrome — individuals develop Alzheimer’s at an earlier age; by age 40 most have significant levels of amyloid and tau
  – Risk genes:
    • APOE-e4 is linked to increased risk of developing Alzheimer’s disease
    • May be dozens of similar genes
Alzheimer's disease is a continuum

- **Asymptomatic**
  - No cognitive symptoms but possible biological changes in the brain

- **MCI due to Alzheimer's disease**
  - Early stage of cognitive ability loss

- **Dementia due to Alzheimer's disease**
  - Mild: Typically involves symptoms that interfere with some daily activities
  - Moderate: More pronounced symptoms that interfere with many daily activities
  - Severe: Symptoms interfere with most daily activities
Normal Aging

Typical age-related changes:

• Forgetting names or appointments but remembering them later
• Making occasional errors when managing finance
• Vision changes related to cataracts
• Sometimes having difficulty finding words
• Misplacing things but successfully retracing steps to find them
• Making poor decisions or mistakes intermittently
• Occasionally uninterested in family and social obligations
• Becoming irritable with change in routine
Mild (or Early) Stage of Alzheimer’s Disease

- Most individuals function independently.
- May require assistance with activities of daily living (ADLs) to maximize independence and safety.
- May continue to drive and work.
Mild (or Early) Stage of Alzheimer’s Disease

Common Cognitive Symptoms
- Misplacing items and losing the ability to retrace steps
- Forgetting appointments
- Forgetting to take medications or pay bills
- Difficulty coming up with the right word or name
- Trouble remembering names when introduced to new people
- Difficulty performing tasks in social or work settings
- Forgetting material that was just read
- Losing or misplacing a valuable object
- Experiencing increased trouble with planning or organizing

Behavioral or Psychiatric Symptoms
- Depression
- Anxiety
- Social withdrawal
- Irritability
- Sleep maintenance
Moderate Stage of Alzheimer’s Disease

- Harder to complete multi-step tasks
- Confused or disoriented more easily
- More problems with memory and language
## Moderate Stage of Alzheimer’s Disease

<table>
<thead>
<tr>
<th>Common Cognitive Symptoms</th>
<th>Behavioral or Psychiatric Symptoms</th>
<th>Other Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficultly navigating familiar environments</td>
<td>Irritable mood/lability</td>
<td>Decreased appetite with weight loss</td>
</tr>
<tr>
<td>Problems preparing meals</td>
<td>Aggressive behaviors</td>
<td>Incontinence</td>
</tr>
<tr>
<td>Problems with simple calculations</td>
<td>Occasional delusions</td>
<td>Occasional myoclonus</td>
</tr>
<tr>
<td>Difficulty with devices (phone or computer)</td>
<td>Increased anxiety</td>
<td>Mild extrapyramidal symptoms (bradykinesia)</td>
</tr>
<tr>
<td>Disoriented to date or location</td>
<td></td>
<td>Rare hallucinations</td>
</tr>
<tr>
<td>Obvious difficulty finding words</td>
<td></td>
<td>Wandering</td>
</tr>
<tr>
<td>Poor judgment</td>
<td></td>
<td>Insomnia</td>
</tr>
<tr>
<td>Mild apraxia</td>
<td></td>
<td>Rare seizures</td>
</tr>
</tbody>
</table>
Severe (or Late) Stage of Alzheimer’s Disease

- Limited language capability with global aphasia
- Require around-the-clock care with apraxia of tasks
- Impaired gait and balance
- Poor recognition of family members
- Hallucinations
- Incontinence is common
- Dysphagia with aspiration; contributes to death
## Vascular Dementia

| Course                                      | • Based on location and extent of cerebrovascular event (CVE)  
|                                            | • Can be stepwise decline  
| Presentation                                | • Temporal relationship between CVE and onset of cognitive impairment  
|                                            | • Subcortical ischemic vascular disease: dysexecutive function  
| Associated Features                        | • Personality and mood changes  
|                                            | • May exhibit parkinsonian features  
| Most Common Risk Factors                   | • Hypertension  
|                                            | • Dyslipidemia  
|                                            | • Diabetes  
|                                            | • Smoking  
|                                            | • Atrial fibrillation  
|                                            | • Amyloid angiopathy  

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**Legend:**
- CVE: Cerebrovascular Event
- ALZHEIMER'S ASSOCIATION

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**Key Points:**
- Vascular Dementia is a type of dementia caused by cerebrovascular events (CVEs).
- The course of Vascular Dementia can be stepwise, depending on the location and extent of the CVE.
- The presentation often includes a temporal relationship between the CVE and the onset of cognitive impairment.
- Associated features may include personality and mood changes, and the possibility of exhibiting parkinsonian features.
- Common risk factors include hypertension, dyslipidemia, diabetes, smoking, atrial fibrillation, and amyloid angiopathy.
Dementia with Lewy Body

<table>
<thead>
<tr>
<th>Course</th>
<th>• Insidious onset with gradual progression</th>
</tr>
</thead>
</table>
| Presentation      | • Fluctuating cognition and functional impairment with parkinsonian  
|                   | • Cognitive symptoms start shortly before or concurrently with motor symptoms |
| Associated Features | • Falls, syncope, autonomic dysfunction  
|                   | • Nearly 50% have severe neuroleptic sensitivity |
| Most Common Risk Factors | • Genetic risk identified but no family history in most cases |
# Parkinson’s Disease Dementia

<table>
<thead>
<tr>
<th>Course</th>
<th>• Insidious onset with gradual progression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation</td>
<td>• Cognitive decline is usually later, &gt;1 year after motor symptoms</td>
</tr>
<tr>
<td><strong>Associated Features</strong></td>
<td>• Apathy</td>
</tr>
<tr>
<td></td>
<td>• Anxiety</td>
</tr>
<tr>
<td></td>
<td>• Depression</td>
</tr>
<tr>
<td></td>
<td>• Hallucinations</td>
</tr>
<tr>
<td></td>
<td>• Delusions</td>
</tr>
<tr>
<td></td>
<td>• Personality changes</td>
</tr>
<tr>
<td></td>
<td>• Rapid Eye Movement (REM) sleep disorder</td>
</tr>
<tr>
<td></td>
<td>• Excessive daytime sleepiness</td>
</tr>
<tr>
<td><strong>Most Common Risk Factors</strong></td>
<td>• Clinical predictors of dementia (age, male sex, greater motor symptoms, hallucinations, REM sleep disorder and vascular risk factors)</td>
</tr>
</tbody>
</table>
Frontotemporal Dementia

<table>
<thead>
<tr>
<th>Course</th>
<th>• Insidious onset with gradual progression</th>
</tr>
</thead>
</table>
| Presentation            | • Behavioral variant: behavioral disinhibition, apathy, loss of sympathy or empathy, perseverative stereotyped speech, compulsive/ritualistic behavior, hyperorality, dietary changes  
• Language variant: loss of word memory, including speech production, word finding, comprehension, grammar |
| Associated Features     | • Extrapyramidal symptoms may be present in later stages  
• Majority present between ages 56 to 65 |
| Most Common Risk Factors| • Up to 40% are familial  
• Occurs in patients with motor neuron disease  
• Brief cognitive assessments often normal |
Thank You!

Q & A
Featured Expert:

Soo Borson, MD
Co-Lead, BOLD Public Health Center of Excellence on Early Detection of Dementia
Professor of Clinical Family Medicine, Keck USC School of Medicine
Professor Emerita of Geriatric Psychiatry, University of Washington School of Medicine
Creator and developer of the Mini-Cog, a first-stage dementia screening tool developed for primary care and freely available in many languages on mini-cog.com.

Current funding: Centers for Disease Control and Prevention, National Institute on Aging, National Institute of Minority Health and Health Disparities, and Keck USC Department of Family Medicine.

Collaborations: Division of Health Systems Research and Implementation Science, Kaiser Permanente Southern California; AltaMed; Presbyterian Homes; researchers at several academic institutions.

Honoraria: for her work as Deputy Editor of the Journal of the American Geriatrics Society, on clinical advisory boards for Roche Genentech, Biogen, and Eisai, for content created for Medscape, and advisory services to California’s Dementia Care Aware, a web-based dementia detection and care training model for primary care clinicians.
BOLD Public Health Center of Excellence on Early Detection of Dementia

Mission, Vision, and Actions to Increase Early Detection

Finding evidence-based strategies for early detection and better care for older adults with dementia and their care partners

Collect and widely share ways to improve detection

Co-create solutions with national partners

Promote change within stakeholder organizations nationwide
DETECTING DEMENTIA IN PRIMARY CARE:

why, how, and who can do it?
Why primary care?

US Geriatric Specialist Workforce v. Persons with Alzheimer Dementia

- **Geriatric Medicine**
- **Geriatric Psychiatry**
- **Persons with dementia**

Why primary care?
Primary care is primary!

**PRIMARY CARE PROVIDERS**
85% of first diagnoses, 80% of care

- “We do it all, birth to death”
- Late and low dementia detection
- Under-developed care framework

**MEMORY DISORDER SPECIALISTS**
15% of first diagnoses, <10% of care

- Access issues, consult model
- Disease vs person focus
- Variable relationship with primary care
  
  *neuro, geri, psych*

The WHY of Detection: Health Consequences of Dementia

- Missed new diagnoses
- Unnecessary crises
- Accidents/injuries
- Medication errors
- Caregiver stress, poor health
- Acute confusion/delirium
- Poor chronic disease control
- Under-, over-, and wrong treatment choices
- Surgical complications
- Discontinuity of care
- Complications of family stress
- Preventable hospitalizations, complications, readmissions
# Dementia increases preventable hospitalizations

<table>
<thead>
<tr>
<th></th>
<th>NEW DEMENTIA</th>
<th>NO DEMENTIA</th>
<th>EFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>494</td>
<td>2525</td>
<td>16%</td>
</tr>
<tr>
<td>Age at enrollment</td>
<td>78 (6)</td>
<td>75 (6)</td>
<td>p = 0.0001</td>
</tr>
<tr>
<td>Length of F/U (yrs)</td>
<td>9.6</td>
<td>8</td>
<td>No difference</td>
</tr>
<tr>
<td>% w/any admit</td>
<td>86%</td>
<td>59%</td>
<td>++</td>
</tr>
<tr>
<td>% with at least one preventable hospitalization</td>
<td>40%</td>
<td>17%</td>
<td>Adj rate ratio 1.78 (1.38-2.31)</td>
</tr>
</tbody>
</table>

2/3 of preventable admissions were for CHF, pneumonia, or UTI. Admits for dehydration and duodenal ulcer occurred only among persons with dementia. Higher risk in poorly controlled diabetes, esp for UTI and dehydration.

Phelan E et al. JAMA 2012; Zaslavsky O et al, J Gerontol 2021
How to do early detection

• Make the decision
• Build it into your workflow – e.g., Annual Wellness Visit
• Start the conversation – a “check up from the neck up”
• Break the ice – ask about symptoms - individual, family/friend concerns
• Take a history
• Use a detection tool – direct and/or proxy test, ideally both (anyone can do it)
• Assess independent activities of daily living
• Talk about results
  If no concern or impairment detected, encourage active reporting
  If impairment detected: discuss choices for further evaluation – one size doesn’t fit all
Dementia-capable health care

- Surveillance: individuals: watch for signs – listen for clues; health systems – use electronic health data.
- Develop an active detection strategy.
- Ask about memory concerns – take a history!
- Assess both cognition and everyday function.
- Engage care partner(s) as members of your team.
- Assess needs across multiple domains* – patient and partners.
- Plan proactively, manage risks intentionally.
- Attend to continuity – relationships are key!
- Optimize staff roles and participation.
- Use multiple modes of care – face to face, remote, in groups.

*Six domains of care: cognitive; emotional, behavioral, spiritual; medical, functional; care partner capacity and readiness; health related social needs; delivery system capacity.
The BOLD Public Health Center of Excellence on Early Detection: How We Can Help

- Early detection toolkit for clinicians and health care systems
- Strategic advice on becoming dementia-capable
- Technical assistance to clinicians, teams, health care systems
- Connection with members of our partner network
Early Detection Toolkit for Health Systems

TABLE OF CONTENTS

Early Detection of Dementia Toolkit - Health Systems

Early Detection Overview

What is Dementia

Early Detection Overview

What is dementia detected?

Where is dementia detected?

Dementia can be detected whenever affected people are — at home in the kitchen, in the supermarket, at the bank, on the bus, at the park, at the food bank, in the senior center, during a blood draw for lab tests — but a clinician is needed to make a medical diagnosis of dementia and identify what conditions and factors, reversible or permanent, are causing it.

This section covers the roles that health systems, communities, individuals, family, and friends can play in dementia detection.

Early Detection Overview

What is early detection?

Why is detection important?

Should routine dementia screening be conducted?

Red flags/indicators for screening (e.g., missed appointments)

Ecological Model of Dementia Detection Stakeholders

Navigating post-screening conversations

Screening for cognitive impairment is a crucial first step to ensuring patients' overall health.

Detailed conversations with patients about their lives and their day to day activities provide context for cognitive screening and establish an important partnership in uncovering opportunities to maintain health. Equipping clinicians to communicate effectively with patients about their cognitive health requires clear communication about the screening process, the steps involved, and the ways in which it may be helpful to the patient in the context of planning for potential needs, although it can be sensitive and often helps to “complete the story.”

This work is never completed or one-off, as there will always be more. This is a journey for both primary care providers and these patients and their families. Primary care is the vehicle for such a journey because this is always about relationships between patients, their families and providers. When impairment is detected, having readily available information in other resources (e.g., community-based organizations, state or local resources) is a critical element of ongoing care.

Building trust

Feelings matter; Use positive framing and pay attention to your body language.

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Building trust

Feelings matter; Use positive framing and pay attention to your body language.
HBI Collaborative
Multi-component approach to fully integrate dementia, cognitive health and caregiving into public health practice

HBI Collaborative

Find us online

• About the HBI Collaborative
• Participating Members
• Contact Information

hbicollaborative.org
Get in Touch!

Contact our team by emailing NYUBOLDCenter@nyulangone.org to submit a request for resource sharing or to join our national partner network

QR code for technical assistance form
Featured Expert:

Barak Gaster, MD
Professor of Medicine
Director of the Cognition in Primary Care Program
University of Washington
Early Detection and Prevention
The Role of Primary Care
82-year-old woman comes to see her PCP for annual wellness visit.

Generally, very healthy.

She happens to mention, “I’ve been worried about my memory.”
Primary Care needs/ wants a path forward

• Don’t just reassure. “Don’t worry, it’s normal.”

• Can’t refer all to Memory Clinic. Lack capacity.

• Not practical to do a cognitive assessment then and there. Lack of time.

• Solution: Schedule a follow-up visit for cognitive evaluation, family member also.
A model to efficiently perform cognitive evaluations
Dementia: primary care disease

- We’re on the front lines.
- Patients trust us.
- Specialists hard to access.
- Goal: a structure to evaluate cognition: improve care: helps us, helps the system.
Better Care from Diagnosis

• Better communication, support, family involvement.

• Makes care easier, less chaotic.

• Take steps to improve **brain health** now: treat sleep apnea, treat hearing loss.
The Need for Education

Make a diagnosis of cognitive impairment

Set a plan for a newly diagnosed patient
With simple tools to use in practice

- Structured framework for evaluation.
- Brain health checklist for prevention.
Enter MoCA results:

Behavioral flowsheet
AD8

A brief observer interview to detect dementia.

Neurology 2005;65(4) 559-64

<table>
<thead>
<tr>
<th></th>
<th>YES, A change</th>
<th>NO, No change</th>
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<td>1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)</td>
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<td>2. Less interest in hobbies/activities</td>
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<td>3. Repeats the same things over and over (questions, stories, or statements)</td>
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Set the next steps:
A plan for the newly diagnosed

• Difficult-conversation ("serious-news") communication model.

• Guidance on when to refer to specialist, and what are key education and support resources to provide.

• Interventions to maintain Brain Health.
Brain Health – Checklist

- **Alcohol:** Limiting to 0-1 drinks will help your thinking.
- **Medications:** Avoid sedating and anticholinergic meds.
- **Contributing Conditions:** Sleep apnea, hearing loss.
- **Exercise and socialization:** Daily walks with a friend.
Using the GSA KAER Toolkit, a workable model for primary care:

- Earlier detection of impairment.
- Better care.
We Can Make a Difference

• Training and tools, easy to share.

• Design by primary care, for primary care.

• PCPs want knowledge, and they need tools to assess cognitive impairment.

• Path to make a difference in early detection, take steps to promote a healthy brain.
Q&A
Provide Us Feedback
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Next Webinar:
May 17, 2023
1:00 – 2:00 pm ET

SHARE YOUR FEEDBACK
Don’t forget! Let us know what you thought about today’s session.