Reducing Use of Antipsychotic medications in Long-Term Care Residents with Dementia: Ten Best Practices

Abhilash K. Desai, MD
Geriatric Psychiatrist
Idaho Memory & Aging Center, PLLC
Adjunct Associate Professor
University of Washington School of Medicine
Dr.abhilashdesai@icloud.com
Disclosure Information


- I have no other financial relationships with commercial interests to disclose.

- I do intend to discuss off-label uses of antipsychotics, antidepressants, and dextromethorphan-quinidine for management of behavioral and psychological symptoms of dementia.
Objective

- Describe the burdens and risks of using antipsychotics in long-term care populations.

- Using real-life cases, discuss Ten Best Practices to reduce antipsychotic use in long-term care residents with dementia.

- Discuss barriers to overcome so that the routine use of best practices becomes a norm in caring for long-term care residents.
Bottom Line

- “We seek to work towards transforming our culture to one honoring human dignity...Let’s be companions together on this journey.”

Key Burdens and Risks of Antipsychotics

- Black Box Warnings in individuals with dementia: stroke and death
- Other serious and life-threatening risks:
  - Aspiration pneumonia
  - Hospitalization
  - Falls and fracture, head injury and other injuries
  - Dysphagia
  - Delirium
  - Extrapyramidal syndrome (Parkinsonism, Akathisia)
  - Tardive Dyskinesias
- Adverse effects
  - Sedation, agitation, insomnia, fatigue, dysphoria, loss of appetite, weight gain

Key Burdens and Risks of Antipsychotics

• New evidence indicates that for many patients with Alzheimer’s disease, antipsychotics can be tapered and discontinued without significant signs of withdrawal or return of behavioral symptoms.
Ten Best Practices

1. DICE Model and STAR Model (with nurses leading the way)
2. Accurate routine measurement of outcomes
3. Rational Deprescribing (with Primary Care Providers leading the way, preferably in collaboration with consultant pharmacists)
4. Pain Management: ATMAN Approach (with Primary Care Providers leading the way)
5. Identification and treatment of reversible physical health conditions (with Primary Care Providers leading the way)
Ten Best Practices

• 6: SPPEICE (with recreational therapists, activity therapists and social workers leading the way)

• 7: STEPS (with nurses and social workers leading the way)

• 8: Rational Non-Prescribing (Medications to avoid for treatment of insomnia and agitation) (with PCPs leading the way) and Rational Prescribing: (with PCPs leading the way)

• 9: Consult Specialists (e.g., recreational therapists, geriatric psychiatrists, music therapists, art therapists).

• 10: Spiritual care (with Chaplains leading)
DICE Model

- Proposed by Dr. Helen Kales, Director, Center for Positive Aging, University of Michigan School of Medicine and her team.

- Describe (neuropsychiatric symptoms)
- Investigate (causes, triggers, contributing factors)
- Create (intervention care plan)
- Evaluate (response to interventions)

  - http://www.programforpositiveaging.org/diceapproach/
STAR Model

- Safety
- Team assessment
- Action Plan
- Response to treatment

Perspectives ofPersons with Dementia

- Every effort should be made to understand the experiences and perspectives of persons with dementia.
Accurate Measurement of Outcomes

- Identifying, measuring (frequency, severity) and tracking two or more most distressing symptoms and or harmful behaviors.

  - American Psychiatric Association 2016 Practice Guideline for the use of antipsychotics in the treatment of agitation or psychosis in patients with dementia.
Rational Deprescribing

• Identify and discontinue medications that are inappropriate in older adults in collaboration with the pharmacist based on the Beers Criteria and STOPP START criteria.

• Identify and discontinue medications that are causing adverse effects, are not in keeping with goals of care, or have not shown clear benefits.

Pain Management: ATMAN Approach

- A: Acetaminophen, Anti-inflammatory medications (e.g., celecoxib)
- T: Topical analgesics (including joint injections)
- M: Migraine medications, Muscle relaxants
- A: Anticonvulsants, Antidepressants (SNRIs)
- N: Non-drug interventions for pain management (e.g., hot and cold therapies, exercise therapy, massage therapy)

Rx of Reversible Physical Health Conditions

- Constipation
- Urinary tract infection
- Dehydration
- GERD
- Vitamin deficiencies (e.g., B12, Vitamin D)
- Pressure ulcers
- REM Sleep Behavior Disorder
- Restless Leg Syndrome
- Other conditions

SPPEICE

• Strengths-based Personalized Psychosocial sensory nutritional Environmental Initiatives and Creative Engagement (aka Non-pharmacological interventions)

STEPS

- Staff Training Empowerment Praise Support (e.g., therapeutic communication / relationship building communication techniques)

The guideline suggests that we Do NOT use trazodone, diphenhydramine, tiagabine, melatonin, tryptophan or valerian for treatment of chronic insomnia.

Valproate is no more effective than placebo for the treatment of agitation in persons with dementia.

Citalopram

- Citalopram was more effective in individuals with dementia who had less severe agitation and less severe cognitive impairment.
Dextromethorphan-Quinidine

• Dextromethorphan-quinidine is approved for treatment of Pseudobulbar Affect (PBA)

• A pilot RCT suggest benefit in the treatment of agitation in persons with dementia.
Methylphenidate for Apathy

- A pilot RCT suggest benefit in the treatment of apathy in persons with dementia.
Delirium

Multicomponent Interventions: Prevention and Treatment of Delirium: frequent reorientation, engagement in cognitively stimulating activities, promotion of sleep with sleep-inducing stimuli (e.g., relaxation tapes, warm milk) and a sleep-promoting environment (e.g. noise reduction), encouragement of physical activity, use of visual and auditory aids, early treatment of dehydration.

Use of antipsychotics does not reduce delirium scores. Individualized management of delirium precipitants and supportive strategies result in lower scores and shorter duration of target distressing delirium symptoms than when risperidone or haloperidol are added.

Major Depression Guidelines

- Canadian Network for Mood and Anxiety Treatments (CANMAT) Pharmacological Treatment of Late-Life Depression: Level 1 evidence: mirtazapine, duloxetine, nortriptyline. Others Level 2 evidence.

Generalized Anxiety Disorders Guidelines

- Escitalopram, paroxetine, venlafaxine, duloxetine, buspirone.
PTSD Guidelines

- Sertraline, Fluoxetine, Paroxetine and Venlafaxine recommended (Va Guidelines); SSRIs (Australian Guidelines).
Parkinson’s Disease Psychosis

- Pimavanserin approved by the FDA for the treatment of PDP.
Cholinesterase inhibitors and memantine

- New studies indicate that cholinesterase inhibitors (donepezil, rivastigmine, galantamine) and memantine have no clinically significant effects on disruptive behaviors.
Consult Specialists

- Recreational therapists
- Geriatric Psychiatrists
- Geriatricians
- Music therapists
- Art therapists
- Occupational therapists
- Speech and Language therapists (Cognitive Communication Specialists)
- Other specialists

Spiritual Care

- Chaplains
- Dignity therapy
- Meaningful rituals
- Gratitude jar

Seven Key Barriers to Overcome

- Lack of Joy at work
- Lack of Knowledge and Skills
- Knowledge and Skills not put into routine Practice
- Institutional inertia
- Lack of access to psychiatrists with expertise in long-term care psychiatry
- Lack of access to geriatricians and geriatric psychiatrists
- Lack of home based dementia care (HBDC)

---

Seven Key Strategies to Barriers to Overcome

- HBDC
- Technology (includes telepsychiatry; electronic decision support; ECHO project)
- Continuous case-based education and training of prescribers (on Practice Guidelines and Best Practices) and caregivers (family and professional)
- Hands on training of staff in therapeutic communication skills
- Quality improvement measures targeting reduction in antipsychotic use
- Culture change practices by the institution

Quarterly Prevalence of Antipsychotic Use for Long-Stay Nursing Home Residents, 2011Q2 to 2017Q1
Many guidelines (e.g., the American Psychiatric Association Practice Guidelines on the use of antipsychotics for the treatment of agitation and psychosis in persons with dementia) are rated according to GRADE (Grading of Recommendations, Assessment, Development, and Evaluation) which is used by multiple professional organizations around the world to develop practice guideline recommendations.

- Guyatt et al 2013.
Terms

• Grade A: High confidence that evidence reflects true effect and further research unlikely to change the confidence level

• Grade B: Moderate confidence and further research may change the confidence level

• Grade C: Low confidence and further research is likely to change the confidence level
  
  – Agency for Healthcare Research and Quality 2014.
15 Recommendations

• 1. Assess type, frequency, severity of symptoms (C)

• 2. Assess for pain, subtype of dementia, other modifiable contributors (C)

• 3. Assess response to treatment with a quantitative measure (C)

15 Recommendations

• 4. Comprehensive treatment plan with appropriate person centered nonpharmacological and pharmacological interventions (C)

• 5. Non-emergency use of antipsychotics used only when symptoms are severe, are dangerous, and or causing significant distress (B)

• 6. Reviewing clinical response to nonpharmacological interventions prior to starting antipsychotics (C)

15 Recommendations

- 7. Risks and benefits discussed prior to starting antipsychotics (C)

- 8. If benefits outweigh risks, start low and use minimum effective dose (B)

- 9. If adverse effects occur, review risks and benefits again regarding discontinuing antipsychotics (C)

  - APA 2016 Guidelines.
15 Recommendations

• 10. If response not clinically significant with adequate dose for 4 weeks, taper and discontinue the antipsychotic (B)

• 11. If positive response, discuss criteria for tapering, past trials, and continued risks with family (C)

• 12. If positive response, attempt to taper and discontinue within 4 months unless past failure of taper (C)

15 Recommendations

• 13. Assess for recurrence once a month during taper and for 4 months after discontinuation (C)

• 14. Haloperidol should not be used as first line except for delirium related severe agitation (B)

• 15. Long-acting injectable antipsychotic medication should not be used (B)

Quantitative Measures

- Neuropsychiatric Inventory Questionnaire (NPI-Q)
- Section E of Minimum Data Set (MDS)
- Cohen Mansfield Agitation Inventory (CMAI)
- Rating of behaviors on a Likert scale (never, rarely, sometimes, often, always)
  - APA 2016 Guidelines.
Doses of antipsychotics and monitoring

- One third to one half the starting doses used for younger adults or the smallest tablet strength available; May titrate upwards if partial response and no adverse effects.

- Abnormal Involuntary movement scale (AIMS) done every six months to monitor emergence of Tardive Dyskinesias.

- Baseline BMI, HbA1c, lipid profile and 12 weeks later and periodically (q3-6 months) after that.
  - APA 2016 Guidelines.
Antipsychotics

- Second Generation Antipsychotics preferred over First Generation Antipsychotics (e.g., haloperidol)
- Risperidone found effective against psychotic symptoms
- Risperidone, olanzapine and aripiprazole effective against agitation
- Insufficient evidence with quetiapine for psychotic symptoms or agitation
  - APA 2016 Guidelines.
Second Generation Antipsychotics

- In patients with dementia with Lewy bodies and Parkinson’s disease dementia, quetiapine and clozapine are preferred over other SGAs.
  - APA 2016 Guidelines.
Improving appropriate use of antipsychotics

- Educational activities.
- Electronic clinical decision support
  - APA 2016 Guidelines.
Definitions / Understanding of various terms

- **Adequate dose**: dose tested in clinical trials that has been found to be effective. Dose may need to be adjusted based on liver and kidney functions, etc.

- **Adequate response**: 50% or more reduction in symptoms
  
  - APA 2016 Guidelines.
Definitions / Understanding of various terms

- Agitation: A state of excessive motor activity, verbal aggression or physical aggression to oneself or others that is accompanied by observed or inferred emotional distress

  - Cummings et al 2015.
Evidence regarding Aripiprazole

- Three randomized controlled trials.
- 1. For BPSD (behavioral and psychological symptoms of dementia): 
  Confidence moderate. **Effect: small.**

- 2. For agitation: Confidence low. **Effect: small.**

- 3. For psychosis: Confidence low. **Effect: nonsignificant**
  
  - APA 2016 Guidelines.
Evidence regarding Olanzapine

• Three randomized controlled trials.

• 1. For BPSD: Confidence low. Effect: very small.

• 2. For agitation: Confidence moderate. Effect: very small.

• 3. For psychosis: Confidence insufficient. Effect: nonsignificant

Evidence regarding Quetiapine

• Three randomized controlled trials.

• 1. For BPSD: Confidence low. **Effect: nonsignificant.**

• 2. For agitation: Confidence insufficient. **Effect: nonsignificant.**

• 3. For psychosis: Confidence insufficient. **Effect: nonsignificant**

Evidence regarding Risperidone

- Three randomized controlled trials.

1. For BPSD: Confidence moderate. **Effect: very small.**

2. For agitation: Confidence moderate. **Effect: small.**

3. For psychosis: Confidence moderate. **Effect: small**

- APA 2016 Guidelines.
Average, Maximum Doses, and Dose Range of Aripiprazole in RCTs

- Average: 10 mg / day
- Maximum: 15 mg / day
- Dose range: 2-15 mg / day
  - APA 2016 Guidelines.
Average, Maximum Doses, and Dose Range of Olanzapine in RCTs

- Average: 5 mg / day
- Maximum: 15 mg / day
- Dose range: 1-15 mg / day
  - APA 2016 Guidelines.
Average, Maximum Doses, and Dose Range of Quetiapine in RCTs

- Average: 75 mg / day
- Maximum: 200 mg / day
- Dose range: 25-200 mg / day
  - APA 2016 Guidelines.
Average, Maximum Doses, and Dose Range of Risperidone in RCTs

- Average: 1mg / day
- Maximum: 2mg / day
- Dose range: 0.5-2 mg / day
  - APA 2016 Guidelines.
Average, Maximum Doses, and Dose Range of Haloperidol in RCTs

- Average: 1.5 mg / day
- Maximum: 4 mg / day
- Dose range: 0.5-4 mg / day
  - APA 2016 Guidelines.
Strength of Evidence (confidence level) for Adverse effects: Mortality

- Grade A (high): SGAs > placebo
- Grade A (high): FGAs > SGAs
- Grade B (moderate): Haloperidol > Risperidone > Quetiapine
  - APA 2016 Guidelines.
Confidence level: Adverse effects

- Grade C (low): Stroke
- Grade C (low): Myocardial infarction and other CVS events
- Grade C (low): Pulmonary events
- Grade C (low): Cognitive changes

- APA 2016 Guidelines.
Adverse effects

- Grade C (low): Falls and hip fracture
- Grade C (low): Diabetes
- Grade C (low): Urinary symptoms
  - APA 2016 Guidelines.
Adverse effects

- Grade B (moderate): Sedation / fatigue
- Grade B (moderate): Extrapyramidal signs and symptoms
- Grade B (moderate): Weight gain
  - APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- Dangerous Agitation: New agitation and assessment finds a short-term reversible cause (e.g., acute delirium, medication-induced, environmental causes)
  - Aripiprazole: 3
  - Haloperidol: 4
  - Olanzapine: 3
  - Quetiapine: 4
  - Risperidone: 4
  - Ziprasidone: 2

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- Dangerous Agitation: New agitation and assessment does not find a short-term reversible cause
  - Aripiprazole: 3
  - Haloperidol: 3
  - Olanzapine: 4
  - Quetiapine: 4
  - Risperidone: 4
  - Ziprasidone: 3

  - APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- Persistent Dangerous Agitation and assessment does not find a short-term reversible cause
  - Aripiprazole: 3
  - Haloperidol: 3
  - Olanzapine: 4
  - Quetiapine: 4
  - Risperidone: 4
  - Ziprasidone: 3

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

• Are there other antipsychotics (FGAs or SGAs) that are highly appropriate for management of Dangerous Agitation?

• 86% said No (N=170)

• 14% said Yes (N=28). Perphenazine and to a lesser extent fluphenazine were considered appropriate

Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- New Non-Dangerous Agitation and assessment does find a short-term reversible cause
  - Aripiprazole: 2
  - Haloperidol: 2
  - Olanzapine: 2
  - Quetiapine: 2
  - Risperidone: 3
  - Ziprasidone: 1

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- New Non-Dangerous Agitation and assessment does not find a short-term reversible cause
  - Aripiprazole: 2
  - Haloperidol: 2
  - Olanzapine: 2
  - Quetiapine: 3
  - Risperidone: 3
  - Ziprasidone: 1

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- Persistent Non-Dangerous Agitation and assessment does not find a short-term reversible cause
  - Aripiprazole: 3
  - Haloperidol: 2
  - Olanzapine: 3
  - Quetiapine: 3
  - Risperidone: 3
  - Ziprasidone: 1

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- Are there other antipsychotics appropriate for non-dangerous agitation?

  - 92% said No.

  - 8% said Yes. Perphenazine
    - APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- New Dangerous Psychosis: New agitation and assessment finds a short-term reversible cause
  - Aripiprazole: 3
  - Haloperidol: 4
  - Olanzapine: 4
  - Quetiapine: 4
  - Risperidone: 4
  - Ziprasidone: 3

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- New Dangerous Psychosis: New agitation and assessment does not find a short-term reversible cause
  - Aripiprazole: 3
  - Haloperidol: 4
  - Olanzapine: 4
  - Quetiapine: 4
  - Risperidone: 5
  - Ziprasidone: 3

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- Persistent Dangerous Psychosis: New agitation and assessment does not find a short-term reversible cause
  - Aripiprazole: 4
  - Haloperidol: 3
  - Olanzapine: 4
  - Quetiapine: 4
  - Risperidone: 5
  - Ziprasidone: 3

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- New Non-Dangerous Psychosis and assessment does find a short-term reversible cause
  - Aripiprazole: 2
  - Haloperidol: 2
  - Olanzapine: 3
  - Quetiapine: 3
  - Risperidone: 3
  - Ziprasidone: 1

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- New Non-Dangerous Psychosis and assessment does not find a short-term reversible cause
  - Aripiprazole: 3
  - Haloperidol: 2
  - Olanzapine: 3
  - Quetiapine: 3
  - Risperidone: 3
  - Ziprasidone: 2

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- Persistent Non-Dangerous Psychosis and assessment does not find a short-term reversible cause
  - Aripiprazole: 3
  - Haloperidol: 2
  - Olanzapine: 3
  - Quetiapine: 3
  - Risperidone: 3
  - Ziprasidone: 2

- APA 2016 Guidelines.
Appropriateness of antipsychotics: Level 1-5 (1=highly inappropriate; 5=highly appropriate)

- Are other antipsychotics appropriate for non-dangerous psychotic symptoms
- 88% said No.
- 12% said Yes. Perphenazine and clozapine
  - APA 2016 Guidelines.
Taper and Discontinue

- 50% recommended taper and discontinuation over around 4 months for dangerous persistent agitation management

- 60% recommended taper and discontinuation over around 4 months for dangerous persistent psychotic symptoms

- APA 2016 Guidelines.
Disciplines / focus of research: researchers and clinicians

- 70% psychiatrists
- 40% geriatrics
- 20% neurology
- 15% nursing
- 5% internal medicine
- 4% family medicine

- APA 2016 Guidelines.
How long in practice? researchers and clinicians (n=185)

- >20 years: 54%
- 11-20 years: 21%
- 5-10 years: 12.5%
- < 5 years: 12.5%

- APA 2016 Guidelines.
Degree of clinical experience? researchers and clinicians (n=185)

- Substantial 75%
- Moderate 25%
  - APA 2016 Guidelines.
Antipsychotics you would refuse to prescribe

- None: 86
- Ziprasidone: 34
- Haloperidol: 28
- Olanzapine: 17
- Aripiprazole: 10
- Quetiapine: 4
- Risperidone: 3

- APA 2016 Guidelines.
Grades of Recommendation

- A: consistent level 1 studies
- B: consistent level 2 or 3 studies or extrapolations from level 1 studies
- C: level 4 studies or extrapolations from level 2 or 3 studies
- D: level 5 evidence or troublingly inconsistent or inconclusive studies of any level

Levels of Evidence

• Level 1a: systematic review (SR) (with homogeneity) of randomized controlled trials (RCTs) OR level 1b: individual RCT (with narrow confidence interval)

• Level 2a: SR (with homogeneity) of cohort studies OR level 2b: individual low-quality RCT

• Level 3a: SR (with homogeneity) of case-control studies OR level 3b: one case-control study

• Level 4: case series

• Level 5: expert opinion without explicit critical appraisal
Limitations of Traditional Medical Model of Care

- Traditional model will not address distress due to unmet psychosocial, environmental and spiritual needs.

- Traditional model does not focus on prevention of behavioral and psychological symptoms of dementia / Bio-Psycho-Social Distress (BPSD)

- Traditional model does not focus on promoting wellbeing (fostering happiness and psychological and spiritual growth)
Person Centered Approach

- “it is not possible to achieve person-centered outcomes solely with traditional medical approaches.”

Health Care Professionals and Persons Having Dementia (PHD)

• “We’ve been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being.” ~ Atul Gawande (2014,p.259)

Person Centered Approach

“A person-centered approach embraces a holistic bio-psychosocial-environmental-spiritual model of care. A person-centered approach considers what is most important to the person, including his or her goals and preferences and seeks to actively promote well-being.”

Person Centered Approach

The most disabling effects of cognitive impairment were found to be the threat to one’s personhood - more than the actual functional impairment.

- Tom Kitwood, geriatric psychologist and father of Person Centered Approaches.
Person Centered Approach

• “We’re caught in a transitional phase. However miserable the old system has been, we are all experts at it. We know the dance moves. With this new way, in which we together try to figure out how to face mortality and preserve the fiber of a meaningful life with its loyalties and individuality, we are plodding novices. We are going through a societal learning curve, one person at a time.”

Person Centered Approaches

- Exercise (e.g., walking program, chair yoga, Tai Chi)
- Meaningful activities - continuous activity programming (e.g., therapeutic coloring, TimeSlips, cognitive stimulation therapy, humor-based activities, cooking, gardening)
- Sensory approaches (touch, music, aroma, Snoezelen [multisensory room])
- High tech (e.g., simulated presence therapy, personalized music)
- Environmental (e.g., safe wandering path, bright light therapy, Eden alternative, lots of natural light, access to nature)
- Spiritual (e.g., prayers, religious rituals and songs)
- Mixed (e.g., animal assisted therapy)
Caregiver Education and Training

- CMS Hand in Hand: A training series for Nursing Homes Toolkit
- DVD: Bathing Without a Battle (University of North Carolina)
- Alive Inside Movie
- Cognitive Stimulation Therapy (http://www.cstdementia.com)
Caregiver Education and Training

- TimeSlips (http://www.timeslips.org)
- Onsite Training by Teepa Snow, occupational therapist (http://teepasnow.com)
- It’s Never 2 Late: Dignity through Technology (http://in2l.com)
- DVD: Mouth Care Without a Battle (UNC)
- Dementia Care Mapping (University of Bradford School of Dementia studies https://www.bradford.ac.uk/health/dementia/dementia-care-mapping/)
Other Key References


Other Recommended Resources


Recommended Reading

Recommended Reading


Recommended Reading


Local Resources

- Alzheimer’s Idaho [www.alzid.org](http://www.alzid.org)

- Alzheimer’s Association Greater Idaho Chapter [www.alz.org/Idaho](http://www.alz.org/Idaho)

- Fun Deficit Disorder: The Problems of Loneliness and Boredom in Long-term Care. By Abhilash K. Desai and Faith Galliano Desai. Contact Dr. Desai via email (idahomemorycenter@icloud.com) for pdf.
Bottom Line

- “We seek to work towards transforming our culture to one honoring human dignity...Let’s be companions together on this journey.”

Thank you for your attention