MICROFILM DIVIDER

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ROLL NUMBER

DESCRIPTION

3022

2007 HOUSE GOVERNMENT AND VETERANS AFFAIRS

HCR 3032

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HCR 3022

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 5, 2007

Recorder Job Number: 2847

Committee Clerk Signature	Judy Schock

Minutes:

Chairman Price: Opens the hearing on HCR 3022.

Representative Lois Delmore, District 43 Grand Forks ND: I am here to introduce the bill, but I will let Mr. Wetzel take over as he has much more expertise in this than I have.

Rodger Wetzel, Director of the Eldercare, Community Health, and Foundation Programs at St. Alexius Medical Center: See attached testimony. Until one goes through this you can not understand the complexity of the challenges when you go to the Dr. with a loved one and he says they have Alzheimer's, and there is not much you can do. You than ask where do we go from here. I will be happy to share information I have put together. See attached.

Kristi Pfliger-Keller, Western ND Regional Center Director with Alzheimer's Association MN-ND Chapter: See attached testimony.

Bruce Murray, a lawyer with the ND Protection and Advocacy Project (P&A): See attached testimony.

Chairman Price: Anyone else to testify in favor? Anyone in opposition? If not we will close the hearing on HCR 3022

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HCR 3022

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 5, 2007

Recorder Job Number: 2848

Committee Clerk Signature	Judy Schmidt

Minutes:

Chairman Price: Let's take out HCR 3022.

Representative Hatlestad moves a do pass consent calendar. **Representative Kaldor** seconds the motion.

Chairman Price asks for discussion, having none the vote was 12 yeas, 0 nays, 0 absent.

Representative Weisz will carry the bill to the floor.

Date: 2/5
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HCR 3022 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do pass Consent Calendar

Motion Made By Rep Hatlestad Seconded By Rep Kaldor

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen	✓		Louise Potter	✓	
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) "Click here to type Yes Vote" 13 No "Click here to type No Vote" 0

Absent 0

Floor Assignment Rep Weisz

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HCR 3022: Human Services Committee (Rep. Price, Chairman) recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (12 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HCR 3022 was placed on the Tenth order on the calendar.

2007 SENATE HUMAN SERVICES

HCR 3022

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HCR 3022

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3-21-07

Recorder Job Number: 5366

Committee Clerk Signature Mary K Monson

Minutes:

Chairman Senator J. Lee opened the hearing on HCR 3022 directing the Legislative Council to study the availability and future need for dementia-related services, as well as funding for programs for individuals with dementias.

Representative Lois Delmore (District #43) introduced HCR 3022 which deals with dementia related services as well as funding for the programs for individuals with dementias. North Dakota has been known as an aging population but this particular issue covers more than simply people who are in that aging population. She gave an example of a person younger than she is who has been diagnosed with Alzheimer's. There is a need for services in North Dakota. Last time they studied definitions. They didn't go into any of the services that are provided. As they look at this particular area, there are over 16,000 people who have dementia in the state of North Dakota and the number is growing all the time.

Discussion indicated that often times when people think of this they think of people who are 70 or older but, unfortunately, there are younger people that have a need for services in the state.

Kristi Pfliger-Keller (Alzheimer's Association MN-ND Chapter) testified in favor of HCR 3022. See attachment #1. She also noted that physical activity and health and obesity can be risk factors in developing memory loss later on in life (meter 06:15).

She pointed out that she is currently working with a 37 year old man who has just recently developed early onset Alzheimer's. He has a family and a business and he faces a whole entirely different shift of needs. He doesn't qualify for a lot of the current services.

Senator Dever asked if they can conclusively determine that a person has a certain dementia.

Ms. Pfliger-Keller said there is not one test. It really is a process of elimination.

There was no opposing or neutral testimony.

The hearing on HCR 3022 was closed.

Senator Erbele moved a Do Pass on HCR 3022.

The motion was seconded by Senator Dever.

Roll call vote 6-0-0. Motion carried. Carrier is Senator Erbele.

Date: 3-21-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HCR 3022

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Erbele

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HCR 3022: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HCR 3022 was placed on the Fourteenth order on the calendar.

2007 TESTIMONY

HCR 3022

HCR 3022 - TESTIMONY
HOUSE HUMAN SERVICES COMMITTEE
Representative Clara Sue Price, Chair
February 5, 2007

Chairman Price and members of the House Human Services Committee, my name is Rodger Wetzel. I am the Director of the Eldercare, Community Health, and Foundation Programs at St. Alexius Medical Center here in Bismarck. I developed our Eldercare Program 21 years ago. For many services, St. Alexius serves much of western North Dakota.

I also am the Vice Chairman of the Board of the Minnesota-North Dakota Chapter of the Alzheimer's Association, and it is in this capacity that I appear before you today.

I have been working in the field of aging in N.D. for 36 years, including serving as a senior services project director; a regional Aging Services coordinator; as the Assistant Director of the state Aging Services Division of the NDDHS; and for the past 21 years as Director of the Eldercare Program at St. Alexius.

I have been interested in, and concerned about, our state's increasing and changing needs for services for persons with dementia, such as Alzheimer's, for many years. It was about 30 years ago that, as a regional staff person for N.D. Aging Services, I did my first presentations on this topic, which was considered a "new" need at the time, to senior and other groups in the Devils Lake region.

In my current position I have served on a nursing home board for 6 years; I developed and chair a statewide conference which addresses Alzheimer's and dementia services; I have facilitated 2 family caregiver support groups for 21 years (one of which we can link to rural facilities via telemedicine) in which I have worked with hundreds of family caregivers; I represent western N.D. on the Minnesota-N.D. Alzheimer's Board; and most importantly, I have 7 relatives who have, or who have had, a variety of dementias, including now both my mother, age 83, and my father, age 88. I have had relatives with dementias in their own homes, in family caregiver homes, in senior apartments, in basic care, in assisted living, and in nursing homes. Some have been in urban areas and others in very rural areas.

I appreciated the study resolution that was passed, and accepted for interim study, during the previous session, which supported studying some of the same issues. But I also then appreciated the need to narrow the topic to studying the legal and regulatory definitions of dementias, since the wording in some of our laws is fairly old, and several different, but

related terms have been used, such as "Alzheimer's," "dementia," memory loss/care," "organic brain syndrome," "incapacitated," etc.

Now is a critical time to study the availability and future need for dementia-related services, as well as funding for programs for individuals with dementias, in this ever-growing population in our state.

For example, we know that thousands of family members struggle with caring for their loved ones with dementias at home. These loved ones have memory losses, mix up days and nights; have delusions, hallucinations, paranoia, and personality changes; often do not accept the fact that they have a dementia; sometimes don't even recognize their family caregivers, and usually do not express gratitude to their spouses or other family members.

In my support groups, about ½ of spouses have shared that they have needed to take anti- depressant medications themselves, due to the stresses and unknowns of caregiving.

Some families need access to 24-hour information and support; others wonder when it is time to place their family member in a facility; while others are confused about locked units in basic care facilities vs. assisted living facilities vs. nursing homes. Many get limited practical information from various medical specialities, including primary care physicians, neurologists, and psychiatrists, who may focus primarily on the diagnosis, but not on the challenges of caregiving, decision-making, and the variety of daily living and behavior problems.

Regarding behavior problems, we do know that many behavior problems do not require medications to manage or control them, but often they can be managed in all environments with appropriate training of family members, agency staff, and facility staff. I appreciate the challenges faced by staff in all agencies who are committed to caring for this population. I have two sisters-in-law, and a sister, who are CNAs, and have worked with older adults.

We also know that family caregivers may need a variety of services to help them, including personal cares, supervision when gone, respite care, day care, or brief (1-2 week) care.

It is very important to our state's aging population, family caregivers, service providers, funding sources, legislators and other policy makers to study the availability of and future needs for dementia-related services, and funding needs for dementia-related programs in our state.

I thank you for your commitment to quality human services in North Dakota, and I appreciate the opportunity to speak to you today in support of this proposed legislation.

I would be happy to answer any questions that you might have. Thank you!

Rodger Wetzel, MPA, LSW, HCA/C
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DEMENTIA:

A loss of intellectual functions (thinking, remembering, reasoning) of sufficient severity to interfere with a person's daily functioning. It is *not* a disease in itself, but rather a group of symptoms which may accompany certain diseases or physical conditions.

ALZHEIMER'S DISEASE:

A progressive, degenerative neurological dementia which affects the brain. It is the most common permanent dementia.

Symptoms include:

- **-gradual memory loss, especially short-term**
- **-decline in ability to perform routine tasks**
- **-impairment of judgement**
- **-disorientation (person, place, time)**
- **-personality changes**
- **-difficulty in learning or relearning skills**
- **-loss of language/word-finding skills**
- **-loss of communication skills**
- **-difficulty with mathematical calculations**
- **-difficulty with abstract thinking**
- **-coordination problems (fine and gross motor)**
- **-disruption of sleep-wake cycle/pattern**
- **-sometimes delusions/hallucinations**
- **-increased anxiety and agitation**

Reprinted courtesy of the Alzheimer's Support Groups at St. Alexius Medical Center.

Some causes of permanent dementias:

Degenerative diseases:

- Alzheimer's disease
- Pick's disease
- Huntington's disease
- Progressive supranuclear palsy
- Parkinson's disease (not all cases)
- Cerebellar degenerations
- Amyotrophic lateral sclerosis (ALS) (not all cases)

Vascular dementias:

- Multi-infarct dementia
- Cortical micro-infarcts
- Lacunar dementia (large infarcts)
- Binswanger disease
- Cerebral embolic disease (flat, air, thrombus fragments)

Anoxic dementias:

- Cardiac arrest
- Cardiac failure (severe)
- Carbon monoxide

Traumatic dementias:

- Dementia pugilistica (boxer's dementia)
- Head injuries (open or closed)

Infectious dementias:

- AIDS dementia
- Opportunistic infections
- Creutzfeldt-Jakob disease (subacute spongiform encephalopathy)
- Progressive multifocal leukoencephalopathy

- Post-encephalitic dementia
- Behcet's syndrome
- Herpes encephalitis
- Fungal meningitis or encephalitis
- Bacterial meningitis or encephalitis
- Parasitic encephalitis
- Brain abscess
- Neurosyphilis (general paresis)

Normal pressure hydrocephalus (communicating hydrocephalus of adults)

- Chronic or acute subdural hemtoma
- Primary brain tumor
- Metastatic tumore (carcinoma, leukemia, lymphoma, sarcoma)

Multiple sclerosis (some cases)

Auto-immune disorders

- Disseminated lupus erythematosis
- Vasculitis

Toxic dementias:

- Alcoholic dementia
- Metallic dementia (e.g., lead, mercury, arsenic, manganese)
- Organic poisons (e.g., solvents, some insecticides)

Other:

Reversible Dementias

Characteristics of reversible dementias:

- Can be reversed or cured
- Temporary condition
- Brain regains lost functions when treated

Common causes of reversible dementias:

- **Brain disease**
  - Tumors
  - Subdural hematoma
  - Hydrocephalus
- **Depression**
  - Response to life's stresses
  - Chemical imbalances in the brain
- **Medication**
  - Negative drug interactions
  - Drug overdose
  - Alcohol abuse
- **Malnutrition**
  - Vitamin (A, C, B-12 and folate) deficiencies
  - Mineral (iron) deficiencies
- **Heart disease -- Lack of oxygen to the brain causes confusion**
  - Arrhythmias
  - Congestive heart failure
  - Myocardial infarction

- **Traumas**
  - Usually due to falls
  - Concussions (skull fractures) or contusions (bruises) to the head
- **Metabolic or endocrine disorders**
  - Thyroid disease
  - Hypo/hyperglycemia and other electrolyte imbalances
  - Dehydration
  - Accidental hypothermia
  - Renal failure
  - COPD (Chronic Obstructive Pulmonary Disease)
- **Infection**
  - Produces fever, affecting brain's cognitive abilities
- **Environmental changes**
  - Visual and hearing loss
  - Loss of daylight and decrease in activities can result in "sundowning"
  - Heavy metal poisoning from gas leaks, exhaust fumes or other toxins

How is Alzheimer's disease diagnosed?

There is no single diagnostic test for Alzheimer's disease. If the presence of Alzheimer's disease is suspected, a complete physical examination and more frequent medical, neurological and psychological evaluations are strongly recommended to establish the progressive nature of the symptoms. Universally applied screening instruments often are used by a variety of professionals (e.g. physicians, psychologists, nurses, social workers, etc.) with the general population, such as the Mini-Mental Status Examination.

A *definitive* diagnosis can only be made at the time of autopsy. The numerous test and evaluation procedures currently employed result only in a *possible* or *probable* diagnosis of Alzheimer's disease.

For a probable diagnosis of Alzheimer's disease, it is necessary to observe a well-documented progression of symptoms. Complete evaluations must be performed periodically using the person's previous performance as the comparison measure. Such evaluations or tests are necessary to rule out conditions other than Alzheimer's disease, particularly reversible forms of dementia.

A complete evaluation should include:

- A detailed medical history.
- A documentation of mental and behavioral changes in recent months.
- A thorough physical and neurologic examination, including the testing of sensory-motor systems, to rule out other disorders.
- A "mental status test" to evaluate orientation, attention, recent recall and the ability to calculate, read, write, name, copy a drawing, repeat, understand and make judgments.
- A psychiatric assessment to rule out the presence of a psychiatric disorder, particularly depression.
- Neuropsychological testing to measure a variety of functions that include memory, orientation, language skills, intellectual abilities and perception.
- Routine laboratory tests, including blood work and urinalysis,
- Health screenings and other testing such as chest x -ray, electroencephalography (EEG) and electrocardiography (EKG), as well as certain specialized tests as deemed appropriate.
- Brain scans, such as CAT, MRI and PET scans

Ten Warning Signs of Alzheimer's Disease or Another Dementia

Some change in memory is normal as we grow older, but the symptoms of Alzheimer's disease or another dementia are more than simple lapses in memory. People with Alzheimer's or another dementia experience difficulties communicating, learning, thinking and reasoning—problems severe enough to have an impact on an individual's work, social activities and family life.

The Alzheimer's Association believes that it is critical for people with Alzheimer's and other dementias and their families to receive information, care and support as early as possible. To help family members and health care professionals recognize the warning signs of Alzheimer's disease and other dementias, the Association has developed a checklist of common symptoms.

Check (✓) if you have seen these signs in your family member or person receiving your care/services.....

Memory loss. One of the most common early signs of Alzheimer's or another dementia is forgetting recently learned information. While it's normal to forget appointments, names or telephone numbers, those with dementia will forget such things more often and not remember them later.

Difficulty performing familiar tasks. People with dementia often find it hard to complete everyday tasks that are so familiar we usually do not think about how to do them. A person with dementia may not know the steps for preparing a meal, using a household appliance or participating in a lifelong hobby.

Problems with language. Everyone has trouble finding the right word sometimes, but a person with dementia often forgets simple words or substitutes unusual words, making his or her speech or writing hard to understand. If a person with dementia is unable to find his or her toothbrush, for example, the individual may ask for "that thing for my mouth."

Disorientation to time and place. It's normal to forget the day of the week or where you're going. But people with dementia can become lost on their own street. They may forget where they are and how they got there, and may not know how to get back home.

Poor or decreased judgment. No one has perfect judgment all of the time. Those with dementia may dress without regard to the weather, wearing several shirts on a warm day or very little clothing in cold weather. Those with dementia often show poor judgment about money, giving away large sums to telemarketers or paying for home repairs or products they don't need.

Problems with abstract thinking. Balancing a checkbook is a task that can be challenging for some. But a person with dementia may forget what the numbers represent and how to do the math.

Misplacing things. Anyone can temporarily misplace a wallet or key. A person with dementia disease may put things in unusual places, like an iron in the freezer or a wristwatch in the sugar bowl.

Changes in mood or behavior. Everyone can become sad or moody from time to time. Someone with dementia can show rapid mood swings—from calm to tears to anger—for no apparent reason.

Changes in personality. Personalities ordinarily change somewhat with age. But a person with dementia can change dramatically, becoming extremely confused, suspicious, fearful or dependent on a family member.

Loss of initiative. It's normal to tire of housework, business activities or social obligations at times. The person with Alzheimer's disease may become very passive, sitting in front of the television for hours, sleeping more than usual or not wanting to do usual activities.

If you recognize any warning signs in yourself or a loved one, it is recommended that you consult a physician for a better diagnosis. There may be other medical problems, some of which are treatable, which are causing the dementia.

The Global Deterioration Scale for Assessment of Primary Degenerative Dementia

Level	Clinical Characteristics
1 No cognitive decline	No subjective complaints of memory deficit. No memory deficit evident on clinical interview.
2 Very mild cognitive decline **(Forgetfulness)**	Subjective complaints of memory deficit, most frequently in following areas: (1) forgetting where one has placed familiar objects; (2) forgetting names one formerly knew well. No objective evidence of memory deficit on clinical interview. No objective deficits in employment or social situations. Appropriate concern with respect to symptomatology.
3 Mild cognitive decline **(Early Confusional)**	Earliest clear-cut deficits. Manifestations in more than one of the following areas: (1) patient may have gotten lost when traveling to an unfamiliar location; (2) co-workers become aware of patient's relatively poor performance; (3) word and name finding deficit becomes evident to intimates; (4) patient may read a passage or a book and retain relatively little material; (5) patient may demonstrate decreased facility in remembering names upon introduction to new people; (6) patient may have lost or misplaced an object of value; (7) concentration deficit may be evident on clinical testing. Objective evidence of memory deficit obtained only with an intensive interview. Decreased performance in demanding employment and social settings. Denial begins to become manifest in patient. Mild to moderate anxiety accompanies symptoms.
4 Moderate cognitive decline **(Late Confusional)**	Clear-cut deficit on careful clinical interview. Deficit manifest in following areas: (1) decreased knowledge of current and recent events; (2) may exhibit some deficit in memory of ones personal history; (3) concentration deficit elicited on serial subtractions; (4) decreased ability to travel, handle finances, etc. Frequently no deficit in following areas: (1) orientation to time and person; (2) recognition of familiar persons and faces; (3) ability to travel to familiar locations. Inability to perform complex tasks. Denial is dominant defense mechanism. Flattening of affect and withdrawal from challenging situations occur.
5 Moderately Severe cognitive decline **(Early Dementia)**	Patient can no longer survive without some assistance. Patient is unable during interview to recall a major relevant aspect of their current lives, e.g., an address or telephone number of many years, the names of close family members (such as grandchildren), the name of the high school or college from which they graduated. Frequently some disorientation to time (date, day of week, season, etc.) or to place. An educated person may have difficulty counting back from 40 by 4s or from 20 by 2s. Persons at this stage retain knowledge of many major facts regarding themselves and others. They invariably know their own names and generally know their spouses' and children's names. They require no assistance with toileting and eating, but may have some difficulty choosing the proper clothing to wear.
6 Severe cognitive decline **(Middle Dementia)**	May occasionally forget the name of the spouse upon whom they are entirely dependent for survival. Will be largely unaware of all recent events and experiences in their lives. Retain some knowledge of their past lives but this is very sketchy. Generally unaware of their surroundings, the year, the season, etc. May have difficulty counting from 10 both backward and, sometimes, forward. Will require some assistance with activities of daily living, e.g., may become incontinent, will require travel assistance but occasionally will display ability to familiar locations. Diurnal rhythm frequently disturbed. Almost always recall their own name. Frequently continue to be able to distinguish familiar from unfamiliar persons in their environment. Personality and emotional changes occur. These are quite variable and include: (1) delusional behavior, e.g., patients may accuse their spouse of being an impostor, may talk to imaginary figures in the environment, or to their own reflection in the mirror; (2) obsessive symptoms, e.g., person may continually repeat simple cleaning activities; (3) anxiety symptoms, agitation, and even previously nonexistent violent behavior may occur; (4) cognitive abulia, i.e., loss of willpower because an individual cannot carry a thought long enough to determine a purposeful course of action.
7 Very Severe Cognitive decline **(Late Dementia)**	All verbal abilities are lost. Frequently there is no speech at all only grunting. Incontinent of urine, requires assistance toileting and feeding. Lose basic psychomotor skills, e.g., ability to walk. The brain appears to no longer be able to tell the body what to do. Generalized and cortical neurologic signs and symptoms are frequently present.

Reisberg, B., Ferris, S.H., Leon, M.J. & Crook, T. The global deterioration scale for assessment of primary degenerative dementia. *American Journal of Psychiatry, 1982, 139:1136-1139*

Relationship Between Alzheimer's Disease Progression and Child Development

Age of acquisition	Ability	Alzheimer's stage at which ability is lost
18+	Parenting Skills (hold baby)	7 - severe AD
12 + years	Hold a job	3 – earliest symptoms of AD
8 – 12 years	Handle simple finances	4 – mild AD
5 – 7 years	Select proper clothing	5 – moderate AD
5 years	Put on clothes unaided	6 – moderately severe AD
4 years	Shower unaided	
4 years	Toilet unaided	
3 – 4.5 years	Control urine	
2 – 3 years	Control bowels	
15 months	Speak 5 – 6 words	7 – severe AD
1 year	Speak 1 word	
1 year	Walk	
6 – 10 months	Sit up	
2 – 4 months	Smile	
1 – 3 months	Hold up head	

Growing up

Birth

Dementia is progressing

Death

COMMUNICATION STRATEGIES

1. **Initial Communication** - look into eyes and introduce yourself(may be every time)
2. **Communicate in positive ("do") rather than negative ("don't") terms.**
3. **Avoid questions by stating information in positive terms.** Offer only 1-2 choices. Show items if possible.
4. **Simplify your message. (5-6 words at most)**
5. **Break tasks into the simplest steps, giving directions one step at a time.**
6. **Speak to the demented person as an adult.**
7. **Use non-verbal communication--touch, tone of voice, facial expressions, and gestures.**
8. **Speak slowly, calmly, deliberately.**
9. **Assess if the person has vision or hearing problems.**
10. **Keep a sense of humor.**
11. **Do not reason or be "logical".**
12. **Don't argue or correct.**
13. **Don't say "Don't you remember?" Don't say "Who am I?"**
14. **Encourage him/her to point/gesture, if possible, if you don't understand what is being said.**
15. **Offer a guess if he/she cannot find the correct word. (Unless this is upsetting.)**
16. **Show interest in what he/she is saying. (Even if you don't understand)**
17. **Use trial and error** - see what works today.
18. **Ask other staff/family what communication techniques are most/least effective. (Do this first!)**
19. **Repeat questions using the same words.**
20. **Reduce background noise - move if necessary.**
21. **Give praise for responses.**

s: r112596.rw

1. Drugs to treat behavior problems

A. Antipsychotic drugs

Brand names: Haldol, Navane, Prolixin, Stelazine, Trilafon, Loxitane, Moban, Thorazine, Mellaril.

These medications are often prescribed to manage symptoms of agitation, anxiety, delusions, hallucinations, hostile behavior, uncooperativeness, and psychosis. Often, these drugs have a sedating effect on behavior. They are not always effective with Alzheimer's disease patients and they need to be closely monitored to avoid oversedation.

Side effects can include shakiness, muscle rigidity (can lead to falls), drowsiness, constipation, increased confusion, stiffness, dry mouth, blurred vision, muscle spasms, dizziness, difficulty urinating, restlessness, fast heartbeat, and a shuffling walk.

B. Antianxiety drugs

Brand names: Valium, Tranxene, Halcion, Ativan, Librium, Xanax, Restoril, Centrax, Buspar.

These medications are often used to treat anxiety and agitation and insomnia when psychotic features are not present. These drugs can build up in the body over time.

Side effects can include oversedation, drowsiness, nervousness, dizziness, headache, unsteady gait (can lead to falls), depression, blurred vision, and breathing problems. Sometimes these drugs can produce a paradoxical reaction of increased restlessness or aggression. Withdrawal from these medications needs to be monitored, especially if the patient has been on them for a long time.

C. Antidepressants

Brand names: Prozac, Elavil, Sinequan, Adapin, Tofranil, Norpramin, Vivactil, Ludiomil, Asendin, Desyrel, Aventyl/Pamelor, Wellbutrin, Zoloft, Paxil.

These medications are often used to decrease depressed mood, improve appetite and sleep, and increase energy and functioning. When they are prescribed, it may take several weeks to a month for them to take effect.

Side effects can include drowsiness, dry mouth, urinary retention, congestion, delirium, blurred vision, constipation, tremors, weight gain, nausea, and dizziness. Patients on these drugs should have their blood pressure checked routinely in both the lying and standing positions. High doses can lead to cardiac irregularities.

2. Drugs to improve memory and thinking

Although many experimental drugs with the potential to improve memory and other basic thinking deficits in Alzheimer's disease are currently being investigated, an early drug was approved for this purpose. This drug is **Cognex**, which increased the amount of the chemical acetylcholine in the brain. The response to Cognex was usually modest, and a positive response is seen only in a minority of patients treated with the drug. Side effects can include liver damage in some patients, which is reversible when the drug is discontinued. Nausea may also occur. This drug generally not used at this time.

Three newer drugs are more commonly used to try to treat people in the early stages. They include **Aricept, Reminyl, and Excelon**. All patients do not experience results, and those who do often experience it for only a limited amount of time.

A drug that became available in early 2004 is **Namenda**, which is used to try to treat people in the middle stages. Sometimes this is used in combination with one of the other three. Again, patients do not experience positive results, and those who do may only experience it for a limited time.

→ name changed to "Razadyne"

"The best guide of its kind."
—CHICAGO SUN TIMES

THIRD EDITION

(a good book for families)

The 36-Hour Day

A Family Guide to Caring for Persons with Alzheimer Disease, Related Dementing Illnesses, and Memory Loss in Later Life

NANCY L. MACE, M.A.
PETER V. RABINS, M.D., M.P.H.

A JOHNS HOPKINS PRESS HEALTH BOOK

Adopt a Brain-Healthy Diet (e.g. oily fish, dark-skinned fruits and vegetables, folic acid)

According to the most current research, a brain-healthy diet is one that **reduces the risk of heart disease and diabetes, encourages good blood flow to the brain, and is low in fat and cholesterol.** Like the heart, the brain needs the right balance of nutrients, including protein and sugar, to function well. A brain-healthy diet is most effective when **combined with physical and mental activity and social interaction.**

Manage your body weight for overall good health of brain and body. A long-term study of 1,500 adults found that those who were obese in middle age were twice as likely to develop dementia in later life. Those who also had high cholesterol and high blood pressure had six times the risk of dementia. Adopt an overall food lifestyle, rather than a short-term diet, and eat in moderation.

Reduce your intake of foods high in fat and cholesterol. Studies have shown that high intake of saturated fat and cholesterol clogs the arteries and is associated with higher risk for Alzheimer's disease. However, HDL (or "good") cholesterol may help protect brain cells. Use mono- and polyunsaturated fats, such as olive oil, for example. Try baking or grilling food instead of frying.

Increase your intake of protective foods. Current research suggests that certain foods may reduce the risk of heart disease and stroke, and appear to protect brain cells:

–In general, **dark-skinned fruits and vegetables** have the highest levels of naturally occurring antioxidant levels. Such vegetables include: kale, spinach, brussels sprouts, alfalfa sprouts, broccoli, beets, red bell pepper, onion, corn and eggplant. Fruits with high antioxidant levels include prunes, raisins, blueberries, blackberries, strawberries, raspberries, plums, oranges, red grapes and cherries.

-Cold water fish contain beneficial **omega-3 fatty acids: halibut, mackerel, salmon, trout and tuna.**

-Some nuts can be a useful part of your diet; **almonds, pecans and walnuts** are a good source of vitamin E, an antioxidant.

Not enough information is available to indicate what quantities of these foods might be most beneficial for brain health. For example, it is not clear how much fruit would have to be consumed to have a detectable benefit. However, a study of elderly women showed that those who ate the most green, leafy and cruciferous vegetables in the group were one to two years younger in mental function than women who ate few of these vegetables.

Vitamin supplements may be helpful. There is some indication that vitamins, such as vitamin E, or **vitamins E and C together, vitamin B12, and folic acid** *(see next article)* may be important in lowering your risk of developing Alzheimer's. A brain-healthy diet will help increase your intake of these vitamins and the trace elements necessary for the body to use them effectively.

FOLIC ACID

Alternative names: Vitamin B-9; folate; pteroylglutamic acid

Definition: Folic acid is a water-soluble vitamin in the B-complex group.

Function: Folic acid works along with vitamin B-12 and vitamin C to help the body digest and utilize proteins and to synthesize new proteins when they are needed. It is necessary for the production of red blood cells and for the synthesis of DNA (which controls heredity and is used to guide the cell in its daily activities). Folic acid also helps with tissue growth and cell function. In addition, it helps to increase appetite when needed and stimulates the formation of digestive acids. Synthetic folic acid supplements may be used in the treatment of disorders associated with folic acid deficiency and may also be part of the recommended treatment for certain menstrual problems and leg ulcers.

Food Sources: Beans and legumes, citrus fruits and juices, wheat bran and other whole grains, dark green leafy vegetables, poultry, pork, shellfish, and liver.

SUPPORT GROUP FOR FAMILY MEMBERS/CAREGIVERS OF PERSONS WITH ALZHEIMER'S, DEMENTIAS AND MEMORY LOSS

St. Alexius Medical Center

(ask at Visitor Information Desk regarding meeting rooms)

No Charge

SECOND TUESDAYS - 7:3 -9:00 p.m.,
Cafeteria Meeting Room III
or
THIRD TUESDAYS - 1:30-3:00 p.m.
Tele-Conference Room, 3rd Floor, Orthopedic Center of Excellence/ Bone & Joint

Caring for a demented person can be very challenging:

1. Memory loss, especially short-term
2. Actions not "rational"
3. Repetition
4. Anxiety/wandering
5. Verbalizations/yelling
6. Gesturing/grabbing/striking out
7. Shadowing/following
8. Hoarding/gathering
9. Hiding things
10. Few expressions of gratitude
11. Few expressions of affection
12. Lack of recognition of caregiver/forgetting who you are
13. Lack of acceptance of caregiver/rejection
14. Accusations (e.g. stealing, "affairs")
15. Resistance ("stubborn")
16. Undressing
17. Continence problems
18. Lack of companionship/intimacy

TO BE PLACED ON THE MAILING LIST OR TO RECEIVE FREE INFORMATION ON CARING FOR PEOPLE WITH THESE DISEASES, CALL THE ST. ALEXIUS ELDERCARE OFFICE AT 530-7389

St. Alexius Eldercare Program PrimeCare

February 5, 2007
Alzheimer's Association MN-ND Chapter
Testimony For
House Continuing Resolution No. 3022
****Dementia-Related Services****
House Human Services Committee
Chair – Representative Clara Sue Price

Chairman Price and members of the House Human Services Committee, I am Kristi Pfliger-Keller, Western North Dakota Regional Center Director, with the Alzheimer's Association MN-ND Chapter. I appear before you today in support of the concurrent resolution to study the availability and future need for dementia-related services across North Dakota.

A similar study resolution was approved during the last legislative session but took on a different tone upon final entry into the Legislative Council selection process. The study did move forward with the intent to examine the legal and medical definitions used for dementia-related conditions. Even though the intent changed, this study could have provided essential insight into dementia-related issues across the state.

Understandably, the Legislative Council is given the daunting task of addressing various studies and the initial dementia study was over-shadowed by other pressing issues. We are grateful for the support and recognition that was given to further examining dementia issues.

I am requesting your renewed support for this essential issue in front of you again today. Over 16,000 people in North Dakota have been diagnosed with Alzheimer's disease. This number is expected to grow dramatically over the next 20 years due to our graying population and the fact the disease is recognized much earlier. Until science catches up with the disease, the growing number of persons impacted by dementia will put increasing demands on home and facility-based services. Some obvious issues will be the availability of care in specialized Alzheimer's units, impacts on the Medicare / Medicaid system, training and availability of caregiver staff, and access to respite care services and adult day programs.

As a state, it would be in our best interest to take a pro-active approach to this potential aging crisis and develop avenues to ensure quality and affordable care is available to our citizens.

While working with hundreds of families and individuals with dementia, I have shared in their many frustrations at attempts to find and secure resources - especially in rural areas.

I hope you will consider supporting this study and building a better future for our aging population. I would be happy to address any questions the committee may have.

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TESTIMONY - PROTECTION AND ADVOCACY PROJECT

HOUSE CONCURRENT RESOLUTION NO. 3022

HOUSE HUMAN SERVICES COMMITTEE

Honorable Clara Sue Price, Chairman

February 5, 2007

Chairman Price, and members of the House Human Services Committee, I am Bruce Murry, a lawyer with the North Dakota Protection and Advocacy Project (P&A).

P&A recommends study of the status and future of services to people with various dementias.

In addition, the Legislative Council should look how to maximize the dignity and independence of persons with dementia. Ideas might include how to promote advanced directives for health care, before or soon after the diagnosis of dementia. For persons whose needs exceed the scope of advanced directives, the Legislative Council should consider guardianship options to maximize independence and quality of life.

The Legislative Council should look to private and public sources of funding for services to people with dementias. For instance, long term care insurance should cover both home and institutional settings. As another example, the State should help educate the public about what services are available, and how to make the best use of them.

P&A would be pleased to answer any questions, now or during the interim.

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March 21, 2007
Alzheimer's Association MN-ND Chapter
Testimony For
House Continuing Resolution No. 3022
****Dementia-Related Services****
Senate Human Services Committee
Chair – Senator Judy Lee

Chairman Lee and members of the Senate Human Services Committee, I am Kristi Pfliger-Keller, Western North Dakota Regional Center Director, with the Alzheimer's Association MN-ND Chapter. I appear before you today in support of the concurrent resolution to study the availability and future need for dementia-related services across North Dakota.

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I am requesting your renewed support for this essential issue in front of you again today. Over 16,000 people in North Dakota have been diagnosed with Alzheimer's disease. This number is expected to grow dramatically over the next 20 years due to our graying population and advancements in diagnostic testing. In addition, nearly 50% of our current nursing home residents are affected by some form of dementia.

The 2007 Legislature has already been faced with direct impacts of this issue including the need for an additional geriatric pysch unit, potential reallocation of nursing home beds, and increases in home and community based services and provider pay.

Until science catches up with the disease, the growing number of persons impacted by dementia will only put increasing demands on home and facility-based services. Some obvious issues will be the availability of care in specialized Alzheimer's units, impacts on the Medicare / Medicaid system, training and availability of qualified caregiver staff, and access to respite care services and adult day programs.

As a state, it would be in our best interest to take a pro-active approach to this potential aging crisis and develop avenues to ensure quality and affordable care is available to our citizens.

While working with hundreds of families and individuals with dementia, I have shared in their many frustrations at attempts to navigate complicated eligibility guidelines, locate trained caregivers and other support services, and the realization of long waiting lists at many specialized memory care units and other nursing facilities.

I hope you will consider supporting this study and building a better future for our aging population. I would be happy to address any questions the committee may have.

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