Dementia Friendly @ Work for Healthcare Education Session (Michelle)

Hello everyone and thank you so much for coming today to learn more about dementia, Alzheimer's disease, and creating a dementia-friendly environment for your patients with cognitive impairment. My name is Michelle, and I've been working with patients and families living with Alzheimer's disease and dementia for almost 30 years. I'm really excited to be here with you today because it's my passion to make sure that providers feel supported in taking care of their patients and their patients' families who are living with cognitive impairment. So I'm really excited to be here with you today. I'm assuming that some of you are here to learn how to handle a situation. When someone comes into your clinic and seems confused or upset, others may want to learn more about how to help someone they know who's living with dementia.

And still others of you may be here because your organization said it was important to be more aware of people living with dementia. Some of you may have a lot of personal and professional experience with dementia, while others, for others, this might be your first time getting any information about this topic in a class. Regardless of where you're starting today, the goal is for you and your team to learn something new about creating a safe and welcoming environment for patients who might be living with cognitive challenges. So today we're going to cover number one, some facts about dementia and the warning signs of Alzheimer's disease. Communication tips and strategies. We'll do a planning activity around that. We're going to talk about creating a dementia-friendly environment. We'll do a case study.

We'll talk about some resources and services that can support your patients living with dementia. And we're going to end with a call to action. So. In front of you is a dementia-friendly at work for health care participant guide. That was emailed to you, so hopefully you can put it in front of you if you don't already have it. You can use this guide to follow along with the presentation and as you can see, we'll also have a slideshow. So let's start with where we are right now. I'd like you to share one word that comes to mind when you hear the word dementia. You can share that in the chat if you like. Just type in a word that comes to mind when you hear the word dementia. Confused. Loss of mind.

Jen? Tentative. Oh. Old. Old. Yeah. Now, these words—confused, loss of mind, tentative, old. Do these words have a positive or a negative connotation? What do you think? You can even give me a thumbs up for positive or a thumbs down for negative, or you can use your reactions. I see Jen giving me a thumbs down. Thank you. Thank you. Yeah. Yeah. Most of the words people typically mention are negative. Isn't that interesting? Think for a moment, I'd like you to think for a moment how that might impact our interactions with people with dementia, if we're coming into those interactions with this mindset of what to expect. Now, how many of you have known someone with dementia or Alzheimer's disease? Raise your hands. Okay. Most of you have known someone with dementia.

And the positive/negative exercise we just did may have shed some light on the stigma around the disease. Now let's review some basic facts about dementia and Alzheimer's disease, starting with this. Can anyone tell me the difference between dementia and Alzheimer's disease? You can just shout it out if you want. What's the difference between dementia and Alzheimer's disease? Dementia is broader than Alzheimer's. Alzheimer's is a form of dementia, but there are many different types of dementia. Excellent. Perfect. 100%. That's it. Dementia is not a specific disease. It's an overall term, like you said, Marietta, that describes a wide range of symptoms associated with either decline in memory or other thinking skills that is severe enough to impact a person's ability to perform everyday activities. It's kind of an umbrella term.

So, if you turn to page two of your participant guide and take a look at these facts. Alzheimer's disease is the leading cause of dementia. It accounts for 60 to 80% of cases. So, chances are, if you're seeing someone with dementia and you guessed it was Alzheimer's disease, you'd be right 60 to 80% of the time. Black and Hispanic Americans are at greater risk than white Americans for developing Alzheimer's, likely due to health and economic disparities. They're also less likely to be diagnosed. Probably for the same reasons. Women are twice as likely as men to have the disease, likely due to anybody? Why am I longevity that's right, longevity they we live longer which means we're more likely to develop Alzheimer's because what's the greatest risk factor for Alzheimer's disease?

Age? That's right. Age is the greatest risk factor for Alzheimer's disease. And since we're all aging, I'm sorry, is anyone not aging? Okay, if you're not aging, see me after class. I'd like to know the secret. But since we're all aging, we're all at risk. Overall, about one in 10 people age 65 and older and one in three age 85 and older have Alzheimer's disease, diagnosed or not. Okay. That's a lot of people. One in 10 over 65. Unfortunately, Alzheimer's disease is a lot more common than most people realize. So, now I'd like to challenge you to think of all the patients at your clinic who are 65 and older. Okay, just imagine them in your mind, all the wonderful, wise 65 and older folks you have in your practice.

And think about this. Statistically speaking, one in 10 of those folks is likely living with Alzheimer's disease. Okay. So research shows that of all those who meet the diagnostic criteria for Alzheimer's, fewer than half have actually received a diagnosis. This means that it's likely that you have many patients in your practice who actually have Alzheimer's or related dementia but haven't been diagnosed, or don't have a diagnosis in their medical record. So. How does this relate to your day-to-day work? If you're a provider, let's say you see 10 patients a day. That's 50 patients a week. If

20% of those patients are 65 and older, that's 10 people. This means that one of your patients every week will likely have Alzheimer's disease, diagnosed or undiagnosed.

If you're in the clinic receptionist, you may help 50 patients a day or 250 patients a week. If 20% of those people that you help are 65 and older, that's 25 people that are 65 and older. Two or three of those people every week will have Alzheimer's disease diagnosed or undiagnosed. So that's a lot. And it presents a real opportunity when working with older adults in your clinic. Being alert for signs and symptoms and facilitating a dementia workup when appropriate gives people access to a diagnosis and opens the door to information and support. Which helps patients and families better understand their symptoms, know what to expect, and learn how to cope. Where to get help, live more safely, and plan ahead. So without a diagnosis, people don't know what's wrong.

And they may not make the best choices. So you can help. If you see the signs, say something, right? If you see something, say something. All right, so let's talk about the signs and symptoms of Alzheimer's disease. In your guide on page three, you'll see a table with the left column listing the signs and symptoms and the right column offering examples of what you may notice in your patient. If you see these signs, it doesn't necessarily mean that someone has Alzheimer's disease or a related dementia, but it is a red flag. And an indicator that a full dementia workup is needed. As these examples do not represent changes that can be explained by aging alone. All right, so let's talk about the first sign. Or red flag. Memory loss that disrupts daily life.

So, one common sign, especially in early dementia, is forgetting recently learned information. People may forget what they had for breakfast. They may forget important dates. They may repeat themselves in a short conversation, like in an office visit. You may hear the same story twice in a 10-minute visit. They may ask for the same information again and again. They may increasingly rely on someone for things they need instead of handling it themselves. So in the clinic, you might notice a patient telling you that they're having trouble remembering things. Now, many times that's sort of dismissed. But research shows that actually, when people report that they're having trouble with their memory, they usually are. And there may be an underlying problem happening, illness happening. Another thing that you might see is a patient forgetting the reason for their visit.

They can't tell you why they're there. Or they come with a significant other, a partner, and they look to that other person for answers to questions that they used to know the answer to, like, how old are you? Or what medications do you take? So these are all the first warning signs of memory loss that disrupts daily life. The second sign is challenges in planning or solving problems. So many people experience changes in their ability to develop or follow a plan or to work with numbers. So they might have trouble following a recipe or making change. That can be really tough. They may have trouble keeping track of expenses or paying bills. Concentrating can be a difficult experience for people.

In the clinic, you might notice that maybe a patient tells you that they're having trouble brushing their teeth because they can't figure out this newfangled automatic toothbrush that never works. Or they may be unable to tell you how they will manage a particular treatment plan or regimen. So they can't tell you how they're going to manage their diabetes, or they can't tell you how they're going to clean their teeth in a way that you've recommended. So the second sign, challenges in planning or problem solving. The third sign is difficulty completing familiar tasks at home, at work, or at leisure. So, as the disease progresses, people with Alzheimer's often find it hard to complete daily familiar tasks. They may have trouble managing medications, driving to a familiar location, or remembering the rules to a favorite game.

In the clinic, you might notice that a diabetic patient is unable to show you how she prepares and injects her regular dose of insulin. Or perhaps you might notice that a patient gets lost finding your office, even though she's been there many, many times before. The fourth sign is confusion with time or place. People with Alzheimer's disease can lose track of dates, seasons, passage of time, and, as the disease progresses, they may forget where they are or how they got there. So this might show up as a patient missing one or more appointments. And then, when you call them for follow-up, they don't even remember that they had an appointment with you. It may also show up as a patient gets to the exam room, says they have to use the bathroom.

You bring them to the bathroom, which is right next door, and tell them to come back to the exam room. And 15 minutes later, you find them wandering in the halls, maybe digging in the medicine closet or something like that. Okay, confusion with time or place is number four. Number five is trouble understanding visual images and spatial relationships. So this might show up like vision problems, but it's actually caused by damage to the brain, not the eyes. So people may have difficulty reading or judging distance. They often have trouble with color contrast, so obviously driving would be impacted by that. Or in the clinic, you might see that someone is not able to see, for example, a black pen on a black countertop.

Or they're unable to understand that a black rug is a black rug and not a hole in the ground. So things like that can happen with visual images and spatial relationships. So you might see people coming in the clinic with a history of falls, recent history of more frequent falls. Or one thing that might be interesting, if you see someone come in the clinic and they can't figure out how to sit in the dental chair or on the medical exam table, they're having trouble with that, that might be a sign, a red flag that something's really wrong. A patient who begins to have trouble with inserting their dentures properly, if they've been wearing for a long time, you know, they're putting the bottoms on the top, et cetera.

So in the next section, we're going to talk about how to make physical changes to accommodate some of these symptoms. But for now, we'll go on to number six. Which is new problems with words in speaking and writing. So people with Alzheimer's may have trouble joining into a conversation or following a conversation, especially as the disease progresses. They may stop in the middle of something they're saying and not realize how to continue. They may forget their train of thought. Now, we've all done this sometimes, but this might be much more frequent. They may struggle with vocabulary and have trouble finding the right words for things. They may have a lot of empty speech in the middle and late stages of the diseases where they're saying a lot, but nothing makes a lot of sense.

So you may see that. In the office, you might see that a highly educated patient is not able to read after-visit instructions. Or a patient tries to ask a question but can't find the right words and becomes really frustrated by that, as we all would. A patient may use the wrong word for things they may say, 'stop touching me with that telescope.' Or something like that. Number seven, the seventh sign is misplacing things and losing the ability to retrace steps. Now, we all misplace things sometimes, but most of us are able to sort of retrace our steps and eventually find what we're looking for. But people with Alzheimer's disease may put things in unusual places. They may lose things and not be able to find it.

They can't retrace their steps. They may accuse others of stealing. Feeling—as they get into the mid-stage, which makes a lot of sense, you know—I—I myself have lost my purse, misplaced it, and then when I went to where I thought it was and it wasn't there, my first thought was someone took it. So it's not really an out-of-place thought, right? It's common to think that, but this may happen more frequently with people with Alzheimer's disease. So, things you might notice in the clinic. When leaving the office, a patient might return in a panic because they can't remember where they parked their car or even if they drove there. Again, a patient might set down their purse or phone in the corner of the office and then forget that it's there.

They may even accuse someone of taking it. A person, a patient, may be coming in and again and again for losing or misplacing their dentures. So, if you see these things, just red flag, right? The eighth sign is decreased or poor judgment. People with Alzheimer's may experience changes in judgment or decision making. So, they may be more susceptible to scams. They may make poor decisions when dealing with money, such as giving large amounts to telemarketers or even to charity where, I mean, that's a good thing, but maybe they're giving much more than they would have before they were ill. And as the disease progresses in terms of poor judgment, people may even be paying less attention to personal grooming. And things like that.

So you might notice in the clinic that a patient might show up to your office wearing a short-sleeve shirt. No sweater, in the dead of winter. Absolutely, 20 below outside and the person's dressed like it's summer. So that's sort of poor or weird judgment. A patient may also tell you that they've been soaking their dentures in bleach to try to brighten them up. Since they look stained, that might be what clearly is a sign that something's wrong, right? That's not a good thing to do. Thank you. All right. Two more. Ninth sign. Withdrawal from work or social activities. So as people begin to lose their memories and their language, it gets kind of scary to go out and interact with others. You know, I think people are afraid they'll make a mistake or others will know that there's something wrong.

So people also have trouble doing things they used to be able to do. So oftentimes you'll see people sort of retreating and not going, are withdrawing from hobbies and social activities or other things. They may have trouble keeping up with things or hobbies and they may avoid being social because of the changes they're experiencing. So in the office, you might see that a patient tells you that they've stopped cooking because it's too much trouble. So often they're not saying, 'I'm not cooking because I can't follow a recipe anymore.' They're saying, 'Oh, it's too much trouble to do that.' So I'm just not going to do it anymore. To save face, if you will. So very crafty and wonderful adaptation for people.

A patient might also tell you that they're no longer getting together with their friends because their friends only want to talk about things they're not interested in anymore. So you might hear things like this. And the final, last but not least, the 10th sign is changes in mood or personality. So you might see, especially even early on, changes in the mood and personalities of people with Alzheimer's. Initially, people may become depressed and withdrawn. Or even more prone to being frustrated because they're not able to do things as easily as they could have. You might, as the disease progresses, see people become more fearful and anxious, more easily upset when they're out of their comfort zone. And we'll talk a little bit more about helping with communication because people may have communication with actions as opposed to words. And we'll talk a little bit more about that later.

But for now, what you might notice in terms of changes in mood and personality at the office is someone who's been easygoing and talkative during visits may now seem more quiet. Disengaged. A patient who's always been friendly with you now may seem more impatient or irritable, or may have angry outbursts for no obvious reason, or just in response to a procedure that they've tolerated well before. That's a lot to say. I have spoken for quite a few minutes about all these signs and symptoms. And I want to ask you now to share your examples. What examples of the warning signs and some symptoms have you seen in the clinic? What do you see? Have you seen?

I've had clients come in and instead of checking in at the front desk, they just walk right down the hallway and kind of indiscriminately choose a room to walk into. Perfect example. Perfect example. Anybody else? Well, I see a lot of patients looking at their spouse or looking at the person who brings them. When I start…your examples made me realize that I think that is how a lot of people deal with it. I think sometimes I think, 'Maybe he's got a an overpowering wife, or maybe her husband always speaks for them.' And I've often wondered. Maybe it is them trying to save their spouse or the person they're caring for embarrassment. Really great insight, Jen. Really great insight.

Now, we've been talking to clinics for some time, some examples that I've heard from other clinics. One clinic provider told me that a patient asked for a snack. And when the person went out to get him a snack and came back, the patient was eating the toothpaste in the dental chair. Another clinic said a patient asked the receptionist three times if she always worked on Saturday. But it was a Wednesday that the patient was there. Another clinic said a patient didn't recognize the doctor he had for 30 years and seen only a month before. A patient didn't remember having a procedure three months ago. A patient asked the receptionist a question, and when the receptionist went to go ask the doctor, she came back to give the patient the answer, and the patient didn't remember she had asked the question. Thank you.

So, these has anybody ever had any of these things happen? I had the not remembering. When they had a last appointment or not being familiar with me, even though we've had conversations. Many times. The other one that I think of is that, and I've seen this obviously more with women, but, but older women who come in and they're just not taking their coat off. And they're not letting go of their purse. They're just gonna they're going to sit in the chair with that. The just not going to cooperate with taking that off. Yeah. Thank you. Great example.

And when you see something that's a new sign or symptom that you haven't seen before, you know— it's a red flag that maybe something has changed with this patient. And as health providers, it's our responsibility to make sure they get the best care and that we understand what's causing these symptoms. So now that we know some of the signs and symptoms that we might encounter in the clinic, let's talk a little bit about how you might effectively communicate with someone who's experiencing these symptoms. So our ability to express ourselves is a basic human need. We all need to feel heard, understood, and valued, right? Everybody has that need. Alzheimer's disease and other diseases that cause dementia damage areas of the brain responsible for communication for both expressing needs and understanding what people are saying.

This can feel a bit like trying to have a conversation in a language that you studied in school, but don't really speak fluently. Did anybody take a foreign language in school? I did. And have you ever tried to have a conversation with people who speak that language fluently? It's not easy, is it? No, it's not. Yeah. Yeah, if you've ever done this you know it takes a lot of mental effort, doesn't it? You're having to think about what they said, translate it and then think about what you want to say. Translate it and then say something. And often by the time you figured out what to say, they are three topics down the road. Right.

I often think of having dementia as being like that, except it's the language—it's English. And you're having to hear what people are saying. Really think about what it is they're saying. Think about what you want to say. And then say something. Oftentimes people have already gone on to other conversations. Actually, for people with dementia, processing language information takes a lot of time. In fact, it may take people with dementia up to 20 seconds to take in what you've said and formulate a response before they can jump back in. So you can imagine that this causes people to sort of not speak as much, or not initiate conversation because it's too hard. Just like if you were at lunch with all the Spanish-speaking people that you befriended because you're trying to learn Spanish, it would be hard for you to jump into a conversation and participate fully. So. Let me demonstrate for you how long 20 seconds feels. Okay, let me get my timer out. Thank you. Okay. So I'm going to ask, Jen, will you play with me on this one? Jen? I'm going to ask Jen. Yes, I will. Okay, I'm going to ask you a question. And then, when 20 seconds has passed, I will let you know. And you can answer the question, okay? Yes. Okay, are we ready? Yes. Yeah. What are your plans for tonight?

[20 second pause]

Jen. I'd like to go to Como Park and walk around the lake and see if there's a concert at the pavilion tonight. Okay. Sounds awesome. How did that feel, that 20 seconds? Thank you. It's very awkward. Awkward. Very long. long. Did you want to jump in and help? Yes. Did you want to tell her how to answer? Yeah. Now, often it's good to know that when we interrupt, we risk making it even harder for the patient, not easier, because it gives them more things to have to process in that time. So this activity gives us a good example of what 20 seconds actually feels like. And reminds us to allow extra time and space for patients with dementia to communicate. So really pausing and allowing the patient to answer. Now, think about this.

If you have other patients, how do you think this waiting and slowing down and waiting 20 seconds for an answer or however long it takes? It might be 10 seconds. How do you think that might help other patients? You don't have dementia. Thank you. Well, I think it gives a patient time to answer when I'm not actually doing something in their mouth. Yeah. Because there's a lot of questions that happen. I can't. I can't right now. Great. Exactly. Exactly. When your provider gives you time to answer, does that make you feel, does that help you to feel more heard and supported and valued? I think so. It gives me time to frame the answer if I have to do some thinking about what that answer should be. Sure. Don't feel rushed.

Don't go rushed. When someone asks me a question and then I don't feel like they've let me answer, it, It's hard to feel a relationship with them. It's more like they did it because they're supposed to do it. They don't really care about the answer. Sure, sure. Yeah. You know, it's hard as providers because we're rushed to see a lot of people. And we're going through our day on, you know, rush mode and autopilot mode as most people do. So it is hard to slow down and to really give space for response. But it's so important for people with cognitive challenges. So although Alzheimer's disease causes brain changes that lead to communication challenges, it's important to know that many aspects of communication remain a strength until very late in the disease process.

For example, people with Alzheimer's disease continue to be able to participate in a give and take conversation. And to read non-verbal and emotional aspects of communication long after their ability to understand and use words is impaired. I once had a patient who, the only, she only had three words that she could say and they were, God bless her, they were, I love you. Those were the three words she could say, but she still took turns in a conversation. So I would say, 'Hello, Mabel, how are you doing this morning?' And she would wait for me to finish and stop. And then she would look at me and say, 'I love you.' And I would say, 'I love you too, Mabel.

You know, how's your day going?' And she would wait for me to talk and stop. She wasn't talking over me. And then she would say her three words again. The tone of the conversation, the emotion behind the conversation, people can really—the strength of understanding body language, tone, a voice, facial expressions. Those matter for people who are cognitively impaired or for people who have Alzheimer's disease and dementia, just as much, if not more than the actual words that you're speaking so that they can understand you. For example, if I say to you, 'Jen, I love you,' and you have Alzheimer's disease. Do you think I love you? Well, even if you don't have Alzheimer's disease, do you think I love you? I think I'd be scared if you said it.

Do you really love me? How do you think I really feel about you? Right? I'm probably mad. Aggressive. Aggressive, yeah. So even when we don't have cognitive impairment, a lot of communication is nonverbal. And so really paying attention to that for people with Alzheimer's disease is important. So on page five of your guide are some additional tips that can help you communicate and interact with someone showing signs of dementia. So let's review some of those. Number one, and this is probably something you already do anyway. But treating the person with dignity and respect. Coming at them with a positive frame of mind, we did the stigma exercise. So the positive/negative exercise, where we know that we're automatically, our brains are sort of thinking, 'this is bad,' right?

That someone with this is bad to have dementia. But what if we sort of came at them with dignity, respect, and positive? You know, this is someone who's struggling with a disease that I can help. This is someone who has abilities that I can enable. So addressing the patient by his or her preferred name shows respect. And of course, talking directly to the patient. Even if the patient can't understand you, it communicates that you respect them. And if they're with a care partner, talk to the patient. The care partner will still hear you and will be able to answer as needed. But speaking directly to the patient communicates that their personhood and that you respect them. Being aware of your feelings. So your tone of voice communicates your attitude.

I love you, right? Uh, do that. Okay. So using a positive, friendly tone of voice or facial expressions is important. Now, of course, we're human and it's impossible to always show up with a smile, but just being aware of how this is communicated is important. So people with dementia may not always understand what we say, but they will always understand how we say it. So, if you find yourself getting frustrated, it may be helpful to just take a breath. Maybe smile inside. And that can really help you turn things around, your feelings around at the time. Another thing you can try is approaching from the front. Identifying yourself and keeping good eye contact. Now, as providers, we may need to come into the room behind someone.

But perhaps walking behind them and then turning around, sitting, making eye contact before speaking. People approaching from behind and talking from behind or touching from behind can really startle someone. With dementia, they have often limited peripheral vision. And so that can feel really scary and start your interaction off a little rockier than you'd like. They also may not remember you, so it's important to identify yourself. Getting at eye level with someone is a sign of respect and has also been shown through research to increase patients' appraisal of the provider's competence. So if you sit down and look at people, they actually think you're more competent, even though you may or may not be more competent, but they think that. So, bonus, right, you get a plus in confidence just for sitting down.

All right. Another thing you can do is to speak clearly. Use positive body language and allow time to respond. Remember the second exercise. Speaking clearly and calmly. And allow the person time to understand the information. Bottom line, slow down. Slow down. Use simple, short sentences. And if the person doesn't respond, try repeating yourself. Say the same thing, just slower. Okay. Use relaxed gestures when you can. If it's really an environment that's very distracting, it may be helpful to pull someone into a quieter space to have a conversation. All right, next. Be patient and supportive. Now, you again, probably already do this in your daily life. But letting the person know that you were listening and trying to understand is really important. Show that you care about what they're saying and try not to interrupt if that's possible.

Using supportive statements like, 'You and I are in this together.' I've got nothing more important to do than to help you or to be with you. We're going to get through this. These are things that really pair you as partners with the person and help them to trust you and to be able to communicate their needs. So that's great. Respond calmly to distress. People with dementia may have trouble remembering their personal or health information, the reason for their visit, even. Or even how they got to the clinic. If someone looks confused or distressed, you can let the person know that you are listening and trying to understand. A calm voice and a smile, reassuring the person that it's okay. Encouraging him or her to continue and offering help.

Knowing that if the person becomes aggressive or threatening, the best thing you can do is to stay calm. Even lower your tone. And try apologizing. Even if you've done nothing wrong. An apology is a, it's like letting the air out of a tire, right? I'm sorry really deescalates a situation. And if all else fails, you can always step away. And get a supervisor. And even if you're not getting an actual supervisor, you can say, 'I'm going to get my supervisor to help us.' And then just get someone who can help with the interaction. So those are kind of the do's. What are the don'ts? Well, I'm only going to give you two. It's really good to avoid criticizing or correcting.

If the person uses the wrong word or says something wrong, it's probably best not to correct them if they have Alzheimer's disease. Instead, just try to listen for the meaning behind what's being said and address that. Arguing also is usually a no-win situation. The person is dealing with a different reality that's real to them. And telling them their reality isn't real is probably as effective as me telling you your reality isn't real. You're likely to dig in and think that I'm the one who's crazy rather than to move in the way that I'd like you to, to be able to help you. So far we've talked a lot. I've talked a lot. You've listened very well. I've talked a lot about the signs and symptoms. And we just talked about some communication tips.

We now know that slow and calm is good. Correcting. and arguing, not so good. Next we're going to do an activity to help us understand the impact of dementia on another thinking skill. Planning. Okay, we've already talked about that a little bit in the 10 warning signs. So, like communication, planning is a very important thinking skill that's impacted by dementia. Without it, even seemingly simple tasks that we do every day may be confusing or even overwhelming for someone living with dementia. Actually, you may be surprised by how complicated seemingly simple tasks actually are. So we're going to find out. Okay. Um, we're gonna, we're going to work as a small group. And together, I'm going to ask you to create step-by-step instructions for a familiar task.

In this case, checking into your clinic for an appointment. So I'm going to assign you this task. And on page six of your participant guide, turn to that. I want you to assume that the person with cognitive impairment has just walked through the front doors of the building. And write down all of the steps to register with reception and end when they are seated in the waiting area waiting to be called for their appointment. Make sure that someone reading your list could follow the instructions successfully to complete the task. And be sure to number each step as you go. Does anybody have any questions? So just to be clear, we are writing out the steps that a person would have to do from the time they pull into the parking lot, right? Of the clinic. Let's say, by the time they open the door to the building. Right? To the time they're seated in the way they've checked in and they're just waiting to be called. Does that make sense? So the time they open the door to the building, not the office building, to the time they're all checked in and seated in the waiting room waiting to be called. Did that answer your question, Jen? It did. Thank you. Right. Everybody ready? All right. Talk amongst yourselves. Come up with your step-by-step list.

Well, I'm thinking it's kind of like the COVID days when you had to knock on the door and they would greet you right at the door. It might be helpful if I knew when my patient was coming in that I could actually greet him or her at the door. So. This, I think, is for us to figure out. The steps that the person is putting into getting into the building, right? That's correct. Step one would be, find the handle and open the door. Then what? Well, I got to figure out where I'm going. Like, am I taking the elevator? What floor? Is this office in it? To Kelly's point, some of that might have been eliminated during COVID if they're greeting you. But if it isn't COVID and they're greeting you, then we need to, we're going to say, find the elevator, right? You can find the elevator. Press the button. Well, if I know I'm going up or down, I'll be going up. Okay, we're gonna say up. Okay. Thanks. So when the elevator gets to the top and opens, then what? No, no, no. I have to get in the elevator first. Okay, I pressed the button to get the elevator to come to me. And then I hopefully the doors open and I enter the elevator. And then I press the floor where I'm going. Right.

And then I get out of the elevator. Okay. And find the door. And walk to the office. Okay. So we better hope that it's well labeled. And that I remember that. Yes. Because I think the question is going to be, am I going right or left when I come out of the elevator? Or straight? Yes. Or straight. Yep. Yep. Okay. So when we get there, then what? Get there? You mean we're at the office? Yep. I'm going to open the door to the office. Okay. And then up to the counter, hopefully, if we don't have to wait for somebody else. Yes. And give my name. Yes.

So then I believe this is the part of the visit where. We usually hand over a lot of that. The clipboard with all the information on it. Oh. All right and I probably, if I'm patient, I might have to give my my card. Because the front desk person might ask if I have new insurance or something. Yeah, we usually do. Yeah, we're going to ask for that information and ask them to fill out that clipboard. Have a seat and fill out that clipboard. That might be a little overwhelming. Because I think there's usually three forms on that clipboard. But some we ask to fill in numbers and some are just like checking a box, general health. and wellbeing. So are we lumping all three? Are we lumping all of those into one step?

Because that's a lot of steps if we do. Checking, reading, and checking the box, reading, checking the box, writing down meds, right? Medications they’re on. I'm wondering if what might be helpful, if the individual looks confused when we give them the clipboard, if we have the emergency contact on there—or whoever made the appointment. Okay. If we could do the follow-up with them. That's a thought. Even by combining all of those, I'm at 15 steps. So let me stop you there. Great discussion. Do you think you combined any different actions or any of those steps could have been broken down further? We haven't even talked about bringing the clipboard back. Waiting again. So, if you had to guess, like, how many steps—if you look at your instruction list, how many total steps do you think it takes? Individual steps do you think it takes to check in? Well over 20. Yeah, 20, probably even closer to 30 if we really, you know, made it. I think it will make a difference if they have, Sorry, Marietta. I don't. I'm thinking it might make a difference in steps if they're alone or if they have somebody with them. Sure. Um, but If the more, if they're alone, there's going to be many, many steps. So exactly. And this exercise shows us that. I mean, I don't think any of us before this exercise were thinking that coming to your doctor's office was the most challenging task that you have to do in a day. I think you can take any task, even making a peanut butter and jelly sandwich, if you break down the steps of that task, you'll see that it's actually a pretty complicated task with many, many steps, right? Yeah.

Planning is a lot harder than we think and we do it with every single thing we do and we know that people with Alzheimer's disease and dementia—the part of their brains responsible for planning—is damaged. So they're going to have trouble with this. Now, if a patient with dementia was struggling with this task of checking in, what do you think could be done to support, not to take over, but to support the person's abilities?

Kelly, you had a suggestion. What did you say that you thought would make things easier? Well, I'm thinking if they had a caregiver with them. But if they don't, if they were struggling to fill out that information. Maybe. Maybe we could assure them that it's okay. If I don't have that information right now. And. And then I, is it okay if I give your wife a call. Mm-hmm. So getting help. Yes. If the person. Go ahead. I think you said to something about having an emergency contact and we, we, we just added that to our forms about six months ago. I think that is really important. I mean, for these types of situations. And a lot of people, we hadn't had it on our form before, but now we do.

And I've used it a couple of times already. Mhm. Mm hmm. Before this activity, do you think that checking into your clinic was easy or hard for patients? I thought it was a really easy process. Yeah, I thought so too. Yeah. What did you learn from this activity? We may be taking a lot for granted. It's an easy process. If we're basing the process on everybody having full cognitive ability. But if you have any kind of cognitive impairment, I can see where it would be really complicated. And I'm just thinking that we would have to be really, really attuned to our patient coming in. Because we don't always know if they have any cognitive impairment. Or something might have changed since we saw them the last time. And if nobody alerts us to that.

I think we're going to want to really be watching there. their visual responses. Right? Right. Exactly. So most people take simple day-to-day tasks for granted. But when you actually break the task down, you find that it's pretty complex. And for someone with dementia who has problems with memory, communication, planning, decision making, any one of these steps can become a challenge. However, with support, it's possible to continue to perform daily tasks. And if we can identify the steps of any task, we can potentially simplify it or offer support where the person is struggling. And by doing this, we can empower our patients to be more successful and independent. So something to think about. Right. Yeah. Okay. Thank you for participating in that activity. Now you have the opportunity to make life easier for someone with dementia.

Just like supporting people with the individual steps of a task, there are little things that you can do to the physical environment to make it safer and more welcoming to people living with dementia. So let's talk about some of the things you can do. First, entrances. So you already brought this up. It should be clearly visible and understood as an entrance. If it's a glass door, you may want to think about putting something on there so people know it's glass and they don't walk into it. You may want to avoid rugs, which can create optical illusions for people thinking that it's a black hole. Even people with Parkinson's sometimes won't cross a black hole or a rug because it looks like a black hole. You want to make sure that once they get into the building, it's clear where your office is. And how to get there. Finding your way around should be really clear. You could use tape that is a pathway to your office. You should have contrast in signs between the words in the background so that people can read it. Signs should be mounted to the door in the spaces they refer to. So the bathroom door should have a sign on it, not above or on the side where that is more confusing for people. Signs should be at eye level and well lit. Avoid using highly stylized or abstract images. Like, you know how, when you go in a Mexican restaurant, and it's like, the lady is a caballera and the man was a caballero—that's very confusing for people with dementia.

So you may want to think about an image and the word together. Thinking about placing signs at key decision points for someone who's trying to navigate your premises for the first time. And especially signage for getting to and from restrooms is important. Because we all know that when you got to go—and you're having trouble wayfinding, that's a bad situation, right? So in terms of lighting, lighting at entrances should be as high-powered as possible and include natural light when possible. You want to avoid pools of bright light and deep shadows. You may use lamps to correct any big shadowed areas that could look like holes to people with dementia. So that could help. Flooring should be plain and not shiny and slippery. Bold patterns on carpets, curtains, or wallpaper can cause some perceptual problems for people.

So as plain as walls and flooring with contrast between the wall and the floor is helpful. Step surfaces can also be dangerous, so adding tape or non-slip strips that are a different color can help people see the difference between each step. Pathways should be as wide and uncluttered as possible with directional arrows on the floor, if that's useful for people. In terms of bathrooms, having a family or unisex restroom or changing facility is super helpful for a lot of people, not just people with dementia, but many times people with dementia need to be assisted in the bathroom. And if you don't have, like, at least one restroom that's unisex, you know, it's hard for the care partner who is often a spouse to go in, say, the men's restroom if it's a woman trying to assist her husband, that can be really awkward. So, having at least one, a handicap-accessible restroom that is unisex can be really, really helpful to a lot of people.

Creating a calming space by reducing overhead announcements and other background noise that can be really confusing for people, playing calming music or adding soothing images or even individual aroma therapy can be calming to people. Offering something soft or smooth to hold, during especially a particular challenging procedure. If you have someone in the dentist office in particular who is trying to get up from the chair, you could try a weighted blanket or use the x-ray blanket, which can serve as sort of a weighted blanket that gives people a cue that they shouldn't get up and is also can be soothing because it's...[inaudible phrase].

Quiet areas for someone who may be feeling anxious or confused can help that person recover enough to independently complete what they were doing. If you can offer comfortable seating areas away from doors, elevators, and potential hazards, that can be good. The layout of an area should be free of clutter and arranged to make it easy to move around, especially for people with physical disabilities. It's good to minimize physical transitions as much as possible. So, like from check-in to the room to check out is better than if you have six stops along the way. Fewer is better in terms of transition. And then being aware of potential safety hazards, like hot coffee pots that we often put out for patients and families, might be a real hazard for someone with dementia who's there on their own.

Area rugs are a trip hazard. Or other items that could pose a risk for someone, including my maybe leaving a tray of sharp tools in the room with an unattended patient. We step out to get some water, leave the tools, come back a second later, or to get an assistant, come back a second later and the person's cutting themselves with some tool or slamming the tools down or something like that. So thinking about this list in your physical space. What are some barriers someone with dementia may have?

Well, I'm just thinking that, in our office, we always have our choice of radio station on. And that really doesn't jive with what you said about a calming kind of background atmosphere from a sound perspective. Right. That might be really disorienting or distracting. But I think I just, I see a lot of issues. Not even with folks who have, any cognitive impairment, but with vision. And being able to navigate. Some of our rooms get a little tight. Yeah. So I'd like you to go to page eight of your guide. And maybe write down a couple of examples. Two ideas that you have to make your office or clinic space more dementia friendly.

And we're going to transition here to explore even more examples. So. We're going to get in our groups again, and I'd like you to look at the case study example that you printed. Jen, you can forward the slide. One more. Nope. Nope. Back in time. Back in time. Just to the case study, I thought I had it here, but I don't. Okay, you have an example of the case study with you and we're going to use the top case study. Can someone read that to the group? If not, I can. I'll read it. Okay, go ahead, Marietta. Okay. Thank you.

An 85-year-old who has been a patient at your clinic for the past 15 years arrives for his dental appointment, which is actually scheduled for next week. He appears confused and upset and says he is sure his appointment is today. He lives about eight miles away, but reports it took him a few hours to find your office. He said he got lost and had to stop a few times to ask for directions. Your office manager notes he showed up last week as well, was confused about the timing of his appointment, and got upset when his appointment date was clarified. She says she gave him an appointment card with the correct day and time clearly written down, which he put in his wallet. What would you do next? What could you do to ensure the well-being and safety of this patient? Great. Thank you so much, Marietta. I'd like you to work as a team for the next 10 minutes or so to talk about: How would you approach this patient?

What would you say or do? What are possible explanations that account for her behavior? In what ways might the situation impact your clinical decision-making regarding the care for this patient? What could you do to ensure the well-being and safety of the patient? What are some next steps? That's a lot of questions I know. But. Just talk about it. What would you do? What do you think? Well, I'm thinking since we've been through this once before. And we know that he got pretty agitated, that I might want to offer him a, I might not want to make a big deal about his being there on the wrong day. My agenda would be to get him settled and calmed down initially. Seat him somewhere where, and help him have the opportunity to calm down.

Well, I think that idea is a good one and it goes along with what they're saying you know what we learned about not arguing and apologizing. And I also think, you know to de-escalate. I think Michelle said, 'Get this: Let some of the air out of the tire. You know, I think that would be good.' But while that's happening, I think somebody should be seen, should, try to see if we could somehow get him in the schedule. You know, it would be nice if we could accommodate him since he is there. Yeah. Yeah. That would make sense. What do you think? Well, I think, you know, if you could get him in, but it's a possibility he might not be able to.

And as I look at this and hear this, it's like, my gosh, he only lived eight miles away and he got lost. And is he even going to be able to get back home? and does there, is there an emergency contact so that maybe if there was one on file, maybe you know, the office manager could possibly call that person and say, you know, so-and-so's here, but we're concerned about him even driving home. Yes, I think that would be an underlying concern for me. is as much as we want to get him calmed and settled, however we can do that. But the bottom line is, is that it really, it doesn't look safe for him to be driving. And to be leaving our office on, without some assist.

Well, Kelly, isn't that one of the reasons that we had talked about getting that emergency contact? I mean, absolutely. Yeah, I think that's great. But now like people like, like say that somebody like this, what if some of them were established people, we may not have done that update. So if we don't have that update on the form yet, what do we do if we don't have an emergency contact? Well, you know, here's what I'm thinking is that, because our practice is in a small town, we do tend to know some of those social resources. Yeah. And you know, I know we need to follow HIPAA. So there's a bit of a challenge there. You know, I do, I do think, and this kind of scares me, but I'm thinking, you know, if we needed to, I suppose we could work with law enforcement to get be that intermediary for us in following up with a family or a neighbor, kind of like they do with welfare checks. Sometimes that HIPAA gets in the way. So that might be a way around that. What do you think?

I think that's a good idea. I also think not just the contact part. I think you're right. We'd have to look into the HIPAA thing. But I mean, it's a safety issue. And that was my point. It's immediate danger, right? I mean, I guess it's everybody's version of what danger or emergency looks like. But if this person, you know, is only eight miles away and it takes a couple hours, I guess the question is, do we think he had the right sense of time? Right? Or do we think he got lost and drove all over? In either case, I think it would make sense to ask, like the police or some authority, to come and help decipher, you know, if they think this person should drive home or possibly lead them home or follow them home to make sure they're okay. What do you think, Marietta? Well, I think that you could certainly ask. I'm not too sure that the, you know, police or the sheriff would be able to respond to something like that. Right. Thank you. I like the idea of maybe somebody having him follow somebody if they possibly could to drive home. Again, he might say, 'I don't need that. I can find my way home.' Thank you.

But he does seem to have this confusion, particularly since he came to the office last week and he did not have, I'm assuming, which was actually, yeah. Didn't he come last week, too? Yes, he did. So he keeps coming every Monday afternoon, even though we gave an appointment for next Monday. If I can't get him, we can't get him in, he might not even come next Monday. Do you think we have any kind of obligation to? Well, at least obviously encourage him to reach out to his primary care doctor. But, you know, could we ask? You know? If he's gone to his primary doctor, if he minds, if we call the primary doctor, or is that stepping over the line?

Yes. You know, when you asked that, I was thinking more of, you know, is it a call we need to make to social services? As a vulnerable adult report. Mm-hmm. Was more the direction that my thinking was going. Yeah, I think that, but I think we have, I think, yes, we probably need to fill out that, but what do we do immediately? Do we do anything immediately now since he's in the office? Yes. And maybe we don't have any openings. Right. I, you know, I just think this doesn't solve it. But the more that we can get him to calm down and see if he is going to look at all like he's in a different spot. Mhm. After a while, but you know, if we have a place to seat him. Let's go. That's going to make him feel like he's being well served.

Mm hmm. Yeah. You know, we're going to need that space. And it's going to take some staff time too, I think, to be reassuring of him. Oh, it scares me to think of him getting back on the road though. Absolutely. It scares me for him. It scares me for anybody who you know, runs a light or does something where he may not have that response time or ability to, you know, to react quickly. Because, I mean, it surely appears like there's cognitive impairment. Yes. So thank you guys so much. This is such a robust discussion and I think it's so great. I think it's pretty safe to say that if someone who's been a long-term patient of your clinic and has been coming for 15 years and now is taking an hour to get to your clinic because they've gotten lost, that it's pretty clear that this is a red flag that something is seriously wrong. And as providers, you are responsible for the health and well-being of this patient as you know. And so I was really happy to hear all of the things you discussed about how you could support this patient. And one question I have for you is, why do you think this might be happening? Why does he keep coming back? Why might he keep, we don't really know, but why might he keep coming back? I wonder if you. I wonder if he's living alone. Might be living alone. He could be taking some medication that is making him confused. It may not be dementia at all.

That's right. But it is a red flag that something's not right cognitively, and a serious one. But we don't know what's causing this symptom. You're absolutely right. Um, one thing to think about is that he may be experiencing pain. Yeah. And the reason he's coming back is because he feels pain. And so he's like, 'Oh, I need to go to the dentist.' And then he goes to the dentist. So that might be something to probe. Whether or not this gentleman is experiencing pain and may help you triage whether or not he needs to be seen right away. Or not—is experiencing pain, you might be more likely to see if you can get them in. And then of course you guys have talked about how you get them home safely.

I loved how you talked about listening empathetically to the situation and responding to the emotional distress and getting him. Sort of calm. Sounds like you've had a stressful day. I'm so sorry. Give me a minute and we'll figure this out together. You might get him something to drink and find a comfortable place to sit while we find out what's happened. If it's your fault, even though you know it's not, doesn't matter, right? The patient, maybe having someone go out and ask the patient, you know, hi. Uh, Dr. Smith, the dentist here. I've heard you've had a rough day and I'm wondering how you're feeling now. Do you have any pain? You might, if the patient doesn't have pain, you might take action to protect the patient as you discussed and ensure he gets home safely, either by checking to see if he has a power of attorney for healthcare in your record.

Maybe calling that person. You could, I've had practices tell me they've called, especially in small towns, that they've called the police and asked for an officer to escort the patient home. To ensure his safety, you could call the Minnesota Vulnerable Adult Reporting Line to report concerns about the patient's safety. You can report an at-risk driver at drive dot mn dot gov and request a driving evaluation exam. Okay. Um, I think, No matter what you do, it's probably important to talk with the patient about your concerns. And the next steps, you might say hi Mr. Smith I'm Dr. Johnson. I heard there's been some confusion about your appointment. Unfortunately your appointment is next week so you're a bit early, I really appreciate your dedication to your health.

You might say, we're dedicated to your health too, and we're a bit concerned about you. We'd like to make sure you get home safely. So I've asked Joanie to help you with that. I would also like to share some of my concerns with your primary care physician and have you make a follow-up appointment with her to make sure you are doing well. Does that sound reasonable? Right. And so you can contact the primary care physician, talk about what's happened and ask about having a dementia workup or ask if the patient has a diagnosis already, if you don't have any record of that. Thank you. So there's many things you can do. If the patient needs to come back again, you can arrange that, maybe you can ask if there's someone at home, that you could call to make sure that that person comes with them to the next appointment.

But there's a lot of conversations to be had. And I think we're all scared of having these conversations. But as healthcare providers, I know that you're dedicated to the health and wellbeing of this patient. And sometimes we do have to have tough conversations. But as long as we can have them with kindness and with the person's health care in mind, they're likely to go as well as possible. So hopefully, that was helpful to you in thinking through your own procedures at the clinic. And maybe some things that you might want to start doing to make it easier for you when these things happen, like potentially adding everyone to list someone to contact if something should go wrong, and permission to do that if there's a concern.

Now maybe not everyone will give you that permission, but many people will. And that could really be helpful to you if and when someone does have a problem. You may start asking people about powers of attorney for health care or advanced directives and things like that that can support people as problems arise, no matter what those problems are. So something to think about as you move forward. Thank you all for being such good participants. Does anybody, based on what you learned today, have any additional things you could do to support the patient? I'm just thinking it would be really helpful if we had a small, comfortable room. You know, space is always an issue. But it would be nice if we, you know, if we had a special space when we do encounter these sort of difficulties. Or somebody comes in and is distressed.

Great suggestion. Maybe even something in your building where it's not in your office, but there's a conference room that's a shared space in your building that you could use, or something like that. Right. Great suggestions. Maybe at your next staff meeting, you could bring this to the team and talk about some things, some ideas that you've gotten from the class, and maybe some things to move forward. Thank you everyone. So there's many resources and supports for people living with cognitive impairment in the community. You know, it's important to know that long lists of resources can be really overwhelming for patients and also for providers.

So I'm going to recommend just two gatekeeper organizations that can help educate and connect you or your patients and their families to the information and services you need. Now, these are in your participant guide on page eight. One is the Alzheimer's Association. You should know that even though this is called the Alzheimer's Association, they serve anybody with cognitive impairment. People with Alzheimer's, people with Lewy body disease, people with vascular dementia, any kind of dementia, people with mild cognitive impairment, anybody. As well as care partners or caregivers. Also, healthcare professionals, the general public, diverse populations, concerned families and friends. And they can help link people to helpful supports based on what is needed in the moment, including for providers. So this is a resource in your back pocket.

The Senior LinkAge Line is also an excellent resource in your back pocket that provides information, assistance, and connects people to resources in the community. So, both I think are really great. And just being aware that giving people 65 brochures is probably, they probably will do nothing with that. One or two actions to take will be much more manageable than a big long list. So I did bring you additional local resources for your clinic that you should have that may be useful as you sort of triage and think about what someone needs. So you have that in your back pocket. And also, I want to draw your attention to Act on Alzheimer's, which, you know, providers need information and support to care for patients.

Act on Alzheimer's offers practice tools, clinical practice tools, videos, and education opportunities like this class for healthcare providers. And you can take a look there on the website if you want to learn more about that. So. I've brought some additional resources, which I emailed to you. And hopefully that will be helpful to you. You can always reach out to me if you have any questions. So. We've covered a lot today. As promised, you learned some facts about dementia and the warning signs of Alzheimer's. communication tips and strategies, including the planning activity we did around checking into your office creating a dementia-friendly environment. We talked about some ideas around that. We did a case study where we talked about a gentleman who came and got lost getting there and kept coming and even with reminders wasn't able to keep it straight.

We talked about some ideas for how to support people through the case study in your clinic. And I also went over a couple of gatekeeper resources and services and gave you a list of other local resources that can support your patients living with cognitive impairment and dementia. As you learned today, there are a number of reasons why a patient might appear to be confused or acting differently than usual. Our role is to notice. To help the patient to feel safe and supported, and if needed to conduct or refer the patient for an evaluation to determine what may be causing their symptoms. Like you said, it could be a medication problem, which is very dangerous. So we want to make sure we get to the bottom of what's causing their symptoms. We can also help by slowing down, adjusting the environment, and connecting patients and families with the resources and supports that they need. So I promised you that we'd end with a call to action. And so we will. In the box on page eight of your participant guide, I'd like you to write down one idea you learned today that you will implement in the next month to help your workplace be more dementia friendly. What's one thing, one action step you'll take?

Maybe thinking about what you need to do next to move forward with your action step or who else needs to be involved.

Well, I'm going to take it upon myself to go through those registration forms. And just look at them to see if there's any way we can make them easier. I think just looking at them again, like through the eyes of somebody who might have cognitive impairment. I mean, there's critical information we need. And so I'm not saying there's going to be lots of changes we're able to make. But. I think just looking at that same question through a different lens, we might be able to make it a little easier. Perfect. And Marietta says to relocate signs for the restroom and also plan on how to continue to train staff on this issue. Kelly, did you have an action step that you'd like to take? I do, and it's really less about the office but it will help the office. And that is that, you know, I've learned so much today, but now I have so many more questions about what some of those symptoms look like from person to person. I would like to do some of my own self-learning and go to that Act on Alzheimer's site [great] and really get a better understanding of what kind of situations I might encounter and what I can do to help that person. That's great. Thank you so much, everybody. I am so appreciative of your interest in being here today. And of your commitment to your patients, especially those with cognitive impairment. But really, everybody. I know what committed providers you are. You wouldn't be here if you weren't. So thank you so, so much.

And for those clinicians in the room who are, like Kelly, interested in advanced dementia training, there is advanced dementia training on the Act on Alzheimer's website. And of course, always contact me if you want to know more. I'm happy to help. Now in the next day or so. You'll receive an email with a link to the evaluation. And I'd like you to complete that. And when you do, you will receive your either certificate of participation or your continuing education credit, depending on your needs. You will receive a follow-up email with evaluation information. And you will, once you complete that evaluation, receive your continuing education and or certificate of participation based on your needs. Does anybody have any questions for me before we adjourn?

I just want to thank you, Michelle. This has been very, very. helpful information. Oh, thank you, Kelly. I'm so thankful to you for coming and showing up to receive it. I agree. I think this is helpful. And I really appreciate that the information is, it's super important. But it's also kind of common sense now that you frame it the way you did. I think looking at our dental practice through the lens of somebody with cognitive impairment or the person that's bringing them to the appointment is going to be a good step in the right direction for us. Yes. I'm so excited. That it's very good for our practice. And some of the things that you had mentioned, I'm going, well, yes, it certainly is going to help someone who has dementia, but also those who do not have dementia can still practice those same steps.

Absolutely. Thank you so much for saying that all of you. I do often think about Alzheimer's disease and dementia a lot like Good Grips. Do you guys know Good Grips? They were designed, they're like kitchen tools that were designed for people with arthritis. But actually, as it turns out, they're just easier to use for everybody. And what I can say about this is that Alzheimer's is kind of the Good Grips of aging— if you can make it work for people with cognitive impairment and dementia, it's going to be easier for everybody who enters your clinic. So thank you so much for showing up today. And for all you do to support your patients, really appreciate it. Look for that email and have a wonderful day. Thanks. Thank you. Bye bye.