Cognitive Care Education

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By

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and Sanfrená Britt

Cambridge
Scholars
Publishing

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This book first published 2020

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-5275-4488-5
ISBN (13): 978-1-5275-4488-8

Dedication: This book is dedicated to all who take care of cognitively impaired individuals. The authors wish and hope that one day, cognitive impairments will be "forgotten" as a condition of the past. Until that day, we will continue to help improve Cognitive Care Education, using this book and the accompanying "Cognitive Care Certification Course." ©

Russell Porter: I dedicate this book to Johnnie and Brett. Thank You for all your love and support during the creation of this book and the accompanying course.

Jeremy Berry: I dedicate this book to my wife Kimberly and our 3 daughters, Zoey, Maya and Layla to whom I owe my desire to leave the world better than when I arrived.

Sanfrená Britt: It is funny how love motivates every part of our being when we are fortunate enough to both give and receive it. My husband Tim and our tribe are the reason I commit my life and my life's work to making the quality of life truly a demonstration of love. This book is dedicated to Tim, Jaz, Takia, Talia, and Tim2, along with each of our little fingers who touch our hearts with their love, smiles, hopes, and dreams.

Note: This book was created as a collaboration with the “Cognitive Care Certification Course (CCCC)” © that leads to a potential “Cognitive Care Certification – CCC”® Designation. You will find a question at the end of each chapter that corresponds with a module in the CCCC. Individuals not enrolled in the CCCC will find the chapter questions useful for future research and additional reading. All authors are affiliated with Texas A&M University-Central Texas (A&M Central Texas) in Killeen Texas (USA). A&M Central Texas is part of the Texas A&M University System comprised of 11 universities and 8 Texas State agencies.

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INTRODUCTION

SHORT HISTORY AND LATEST LITERATURE REVIEW ON COGNITIVE IMPAIRMENTS

Theme for the Book: **"Compassionate Care = Care with Dignity"**

Welcome! We congratulate you on accessing this book to improve the care provided to those who have cognitive impairments.

Chapter/Module Instructors:
Professor – Russell Porter, Ph.D., Ed.D.,
Assistant Professor – Jeremy Berry, Ph.D., and
Instructor – Sanfrená Britt, M.S. (Ed.D Candidate)

This book is the outcome of three state-level studies (Porter 1994; Porter, Flanders, and Parson 2004; Porter et al. 2018) and one national study that indicated a significant need for comprehensive instruction like this, especially for those working in long-term care facilities such as nursing homes and assisted-living facilities. We also encourage family and friends who are caregivers in the home of cognitively impaired loved ones to read this book. If you know others who care for cognitively impaired individuals, please introduce them to this book.

We start with definitions of cognitive impairment and cognitive care education:

> Cognitive Impairment: ***"Memory loss that leads to dysfunction in daily living due to dementia, delirium and/or depression"*** (Sources: Cohen and Eisdorfer 1986; Feil and de Klerk-Rubin 2012; Gruetzner 2001; Mace and Rabins 1999; Petersen 2006; Reisberg, Ferris, and Franssen 1985; Warner 1998).
>
> Cognitive Care Education: ***"Amount and type of education provided to cognitive care providers on how to care for the cognitively impaired including knowledge and skills to understand cognitive impairments and requisite standards to improve quality of care and life"***
> (Source: Porter et al. 2018).

We believe that by reading this book, you will have a minimum threshold needed to understand the basics of cognitive care. Twenty-clock-hours of training—the time it takes to read this book and complete the Cognitive Care Certification Course© that accompanies it—will provide a foundation of knowledge and skills to understand cognitive impairments, the standards that can improve the quality of care and life for all types of cognitive impairments, and help improve the compassion needed for those who have cognitive impairments to live with dignity.

Short History of Cognitive Care

The road for compassionate cognitive care is littered with inappropriate interventions, as we discuss below. However, it should be stressed that the greatest issue with cognitive care is the significantly low amount of cognitive care education to begin with—as found in New York State nursing homes during the late 1980s to the present (i.e., education less than 4 hours), as found by Porter et al. (1994; 2004; 2018), and in the entire United States nursing homes at present (i.e., less than 6 hours) as found by the three authors of this chapter. We also found that it takes at least 20-clock-hours to understand the basics of cognitive care, and only a few organizations provide that amount of training. Unfortunately, the number of cognitively impaired individuals is growing, with projections showing that number climbing from over 5 million today to over 13 million by 2050 – in the United States alone (Alzheimer's Association 2018). The explosive growth of this population will place an unprecedented demand on our systems of care. It is possible that a significant number of cognitively impaired people will go without proper cognitive care for some time—unless there is a revolution in cognitive care education soon—which emphasizes the need for this book!

While we are still woefully below the needed amount of cognitive care education at the national level, it was even worse when cognitive impairments were first studied in the United States in the early 1800s. The first known study of a cognitive impairment was conducted by Benjamin Rush in 1812 (Rush 1812). Rush indicated that a cognitive impairment was known as a “derangement,” meaning that the actions of the individual with a memory problem was due to either a “morbid action in the blood vessels of the brain…or extending to the nerves” (Rush 1812, 27) or “laegins” [lesions of the brain] (Rush 1812, 281). We know today, and as explained further in the book, that cognitive impairments are indeed due to cardiovascular issues of the brain (i.e., blood vessels), or neuritic plaques and dendrite impairments of the brain. We will also explain further in the book that cognitive impairments are due to other potential causes such as genetics, viruses, or toxins.

Rush further explained that derangement included “dissociation” from ideas, and the individual with dissociation exhibited an “inability of the mind to perform operations of judgement and reason” (Rush 1812, 259). Further, Rush explained that words substituted for “oblivion” of a specific word had little relation to the forgotten word (Rush 1812, 262), and events could be forgotten but numbers were not “obliviated” or were the last to be forgotten (Rush 1812, 279).

What Rush contributed to the beginning of cognitive impairment care is to recognize that oblivion or forgetfulness occurs initially with “the most recent…events” (Rush 1812, 279). Recognizing that individuals with cognitive impairments forget the most recent past first, before long-term events, this knowledge is helpful for the caregiver. When a caregiver can assist with recalling memories from the past that are comforting to the cognitively impaired individual, without emphasizing the most current memories that may be forgotten, the outcome presents a means to alleviate frustration or even despair and allows for a more compassionate situation that is counter-intuitive to the traditional model of care for the physically impaired. The approach employed for the physically impaired is centered on the present, and knowing “person” – “place” – “time” to ensure valid communication among caregivers; however, this focus may lead to anxiety or worse for the cognitively impaired.

Rush was also the first to explain that there are stages of cognitive impairments (i.e., dissociation), with two, primarily, known in 1812 (1812, 291): 1. first stage as “Derangement,” and 2. second stage as “Total Absence of Understanding and Memory.” The second stage led to a “total paralysis of activity in the will” (Rush 1812, 291) that meant there was very little interaction with the cognitively impaired. Today we know that second stage identified by Rush as the last two stages identified by Reisberg (Reisberg, Ferris, and Franssen 1985). We will provide the seven stages of cognitive impairment identified by Reisberg later in the book.

Whereas Rush provided a foundation for understanding cognitive impairments in the United States, he also provided some “littering” along the road to cognitive care education, and for cognitive care in general. Rush’s remedies for cognitive care were based on the science of his time, and primarily in the physical care needs for the cognitively impaired—

which is a continuing model today for most skilled nursing facilities/nursing homes. For example, Rush provided remedies for derangement that included “bleeding [an intervention used for many medicinal issues in his day], low diet [that meant fewer calories and protein], and purges” (Rush 1812, 262). He also indicated that if the derangement was “periodical” or continuing, that “bark” and other “tonics” could be used (Rush 1812, 262). Both the bark and tonics of his day were long ago discarded by physicians as having no medicinal value.

Rush did start to provide some nonclinical suggestions for cognitive care, although they were minimal and again more of a “littering” than a useful guide for care. His perspectives on cognitive care included “frequently repeating what we wish to remember” (Rush 1812, 286), although we now know that the repetition can be frustrating for the cognitively impaired in the middle stages where recent memories may be fading, and that repetition may actually increase frustration rather than decrease anxiety.

One positive suggestion by Rush (1812, 289) was to introduce poetry or singing, along with music to moderate anxiety manifested by the cognitively impaired. What we know today is that music is indeed a moderating intervention for the cognitively impaired, especially if they were musicians of any kind during their lifetime, professional or amateur. The music that is most remembered includes songs from earlier stages of the cognitively impaired person’s life. In many cases, if the care providers can play instruments and songs from those earlier stages, it will have a soothing effect upon the cognitively impaired.

A final note by Rush (1812, 279) that is important for cognitive care is to know that an outcome of derangement might be an “excess in venery.” Although we do not want to make a generalization about all cases of the cognitively impaired, it is a potential situation in which venery, or moderate to excessive sexual desire, may appear. In some cases, there may actually be a diminished or non-sexual orientation of the cognitively impaired towards anyone, including a spouse or significant other. But venery, or non-normal sexual desire, may be evident, and cognitive care providers should be aware if it exists. It may also be noteworthy to highlight that cultural expectations surrounding what constitutes "normal" sexual desire in aging adults may greatly affect how they are treated by clinicians and direct care staff (Moore 2018). This may lead to misconceptions surrounding sex and sexual health and may affect how these issues are discussed with the cognitively impaired. A case is presented to help understand the "venery" situation and how to handle it.

[Note: all cases are real situations experienced either by one of the authors or a professional known by the authors, with names changed to protect the confidentiality of individuals.]

CASE ONE: Venery in the "Prim and Proper" Mother

This case occurred in a subacute care facility that included a nursing home with a dedicated unit for the cognitively impaired within an assisted-living setting. The primary focus is an 81-year-old female, "Dora," living in the nursing home section of the facility who is experiencing early-stage Alzheimer's Disease (AD). Dora was located on the north section of the nursing home close to, but not in, the unit for the cognitively impaired. Dora is a widow with two daughters living close by. She knew that she was "losing" her memory. She received appropriate care for her physical needs in her own unit, but the nursing staff began supplementing that care by bringing her into the cognitive impairment unit for some of the physical and cognitive activities that were offered to the cognitively impaired residents, especially when her memory began fading.

The issue that required a "touchy" family discussion with staff was the fact that Dora would go missing for long periods of time, usually an hour *or two, during the middle of the day. Dora would show up for her breakfast, lunch, and dinner meals, but staff had a feeling that she was starting to be "very" interested in a specific male resident in the assisted-living section of the facility. We will call the male resident "Tom." Tom, 55, was tested for low cognitive abilities at an early age but Down's Syndrome and similar cognitive disorders /syndromes were ruled out.*

After two weeks of Dora and Tom "disappearing" during the middle of the day, nursing staff decided to see if the two were "eloping" to any particular area of the facility, especially if they were together in another resident's bedroom or suite other than Dora's or Tom's. What the nursing staff found was that Dora and Tom had indeed "eloped" to other suites and used the beds of unsuspecting residents for their sexual encounters. The staff found Dora and Tom together on more than one occasion, and thus established a situation where the "venery" of both needed to be assessed. Tom was a ward of the state, and the ombudsman for Tom had no issue with Tom experiencing a "natural" situation. However, for Dora and her daughters, who were her guardians due to the AD, it was an entirely different situation.

When Dora's daughters were asked to talk with the staff of the facility, they were very amenable and had interacted with the staff on many occasions. However, this was a situation that was new to the staff, especially since they had recently completed their cognitive impairment training and knew they needed to keep the family informed of their mother's actions. What the staff knew about Dora was that her daughters always referred to her as their "Prim and Proper" mother, with a very specific upbringing that included the best in education, and the best in care—she did indeed have one of the best suites in the facility.

The encounter between the daughters and the staff started with pleasantries and an update on Dora's physical health. These included minor ailments that were known for many years and which required a level of care beyond the daughters' abilities at home, hence the intervention of a nursing facility. When the cognitive impairments were discussed, the daughters knew their mother was in the early stages of AD and expected her to move to the cognitive care unit soon. But when the situation regarding the encounters between Dora and Tom was brought up in a manner that was based solely on the facts, without judgement or any suggestions for interventions, one daughter was very vocal and exclaimed loudly, "THAT IS NOT MY MOTHER." The staff only reiterated the facts and wanted to know if the daughters would "permit" Dora and Tom to continue with "the visits" or if they had another suggestion that the staff would assess with them. The first daughter, who spoke loudly as indicated above, spoke loudly again and said, "THAT IS NOT PERMITTED!!"

However, the second and younger daughter, who was evidently closer to her mother, knew something the first daughter did not. As the staff sat quietly, the second daughter turned to her sister and said in a very calm voice, "Sister, you do not know about mom's teenage years because she was working while you were growing up and you never 'really' got to know her. However, as you know, I was close to mom when I was growing up because we were better off financially and mom did not work. Mom once told me she was 'adventurous' during her time before dad, and she had a few boyfriends who were 'fun'—meaning she told me she had sex before dad, especially in places that were not 'condoned' by the public." The staff immediately knew that the Dora and Tom encounters were very similar to the time before Dora's husband, since Dora had started to speak more about her teen years than she spoke about the recent past. It appeared that Dora's AD was *advancing to the middle stages and that the early years (e.g., teens) were more in focus in her mind than the recent past.*

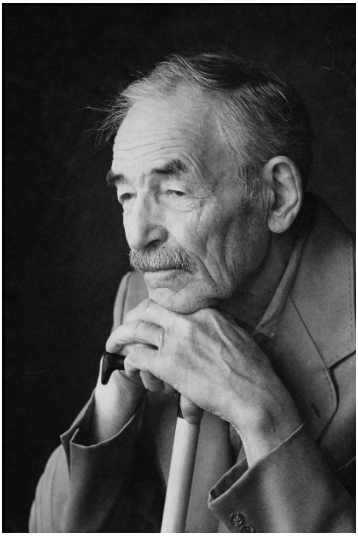
The conclusion that was reached with the daughters, after many discussions over several days, was that Dora would be moved to the cognitive impairment unit. There would be "Visitation" days for Dora and Tom that were appropriate in one of their suites, and staff would give them their space during "their time." Through open and continuing communication that was compassionate for all, Dora and Tom continued to be happy, and the daughters eventually became friends with Tom as well—their father had passed away over 10 years before the Dora and Tom encounters.

For cognitive care providers, it should be noted that "venery" is a possible situation that will need direct and open communication between all parties, **including the person with the cognitive impairment, if possible**. Dora and Tom were not at a point where they were able to help the situation, but they were eventually asked if they wanted to be together, with both affirming they did. If the cognitively impaired can be consulted on their own care, it is strongly suggested they be included for a more "compassionate" orientation.

Latest Literature Review on Cognitive Impairments

There are many types of cognitive impairments including those that are treatable and those that are not. What we need to remember before we review the cognitive impairments and the reason for this book, is that individuals are more than memories—we are "feelings, imagination, desires, drives, will, and moral being" (Cohen and Eisdorfer 1986, 22). With all that we are beyond our memories, we need to pay attention to the "whole person" for those who have cognitive impairments. The subtleties of the person beyond the memories is important, and in most cases, we "live for the moment" with the cognitively impaired—with whatever moment it is for them, not us.

Using our definition of cognitive impairment noted earlier, we turn to a more specific form of cognitive impairment, and that is dementia. While cognitive impairment can include syndromes that include multiple issues, such as Down's Syndrome based on genetics that is really a cognitive disability, and delirium or depression, our focus in this book is dementia related care. Whether you are a care-provider in the home, an assisted-living facility (ALF), a nursing home, or a SNF (nursing home with Medicare coverage), the following pertains to all of those settings.



The most prevalent form of dementia, and cognitive impairments combined, is Alzheimer's Disease (AD) as indicated by Petersen (2006), and the Alzheimer's Association (2018). Petersen also indicates the common components of AD, and non-treatable cognitive impairments, include the following: "Memory Decline, Language Decline, Visual Decline, Executive Functioning such as abstract thoughts and managing finances, Inability to Recognize Familiar Objects, Decline in Motor Activities (i.e., Activities of Daily Living [ADL] such as eating, toileting, mobility, transfer), Attention Deficits, and Loss of Muscle Coordination" (2006, 42–43). Since AD is the most prevalent form of cognitive impairment, making up 60%-70% of cognitive impairments in elderly patients (Alzheimer's Association 2018), we will focus on it for the majority of the literature review. We start with the history of AD as determined by Alois Alzheimer in 1906 (Berrios 1990). What Alzheimer found was a “presenile dementia” case that included tangles and plaques in the brain dissection of an individual. As Alzheimer observed the patient before death, he found many of the symptoms we will describe below, including recent memory loss, and issues with Activities of Daily Living (ADLs) (Cipriani et al. 2011).

We describe AD with an overview of the different phases, with Reisberg (Reisberg, Ferris, and Franssen 1985) providing the most known and specific level of phases. As presented by Rabins, Lyketsos, and Steele (1999), Zarit and Zarit (2011), and Noel, Kaluzynski, and Templeton (2017), we list the Reisberg phases and then describe the type of interventions throughout the book:

[**Note:** The authors have “recounted” the Reisberg seven stages in their entirety within brackets, with the recount at 16. We refer to the recount as Reisberg (Reisberg, Ferris, and Franssen 1985) revisited]

[1] Stage 1: *Normal Adult*: No functional decrement

[2] Stage 2: *Normal Aged Adult*: Deficits in recalling names, or other words, location of objects, recalling appointments

[3] Stage 3: *Incipient AD*: Deficits noted in demanding occupational and social settings. Problems may be noted in traveling to new locations.

[4] Stage 4: *Mild AD*: Deficits in performance of complex tasks in daily life (e.g., paying bills on time)

[5] Stage 5: *Moderate AD*: Deficient performance in ADLs such as grooming, assistance is required in independent community functioning

[6] Stage 6: *Moderately Severe AD – Level A*: Requires physical assistance with dressing

[7] Stage 6: *Moderately Severe AD – Level B*: Requires bathing assistance

[8] Stage 6: *Moderately Severe AD – Level C*: Requires assistance with mechanics of toileting

[9] Stage 6: *Moderately Severe AD – Level D*: Urinary incontinence

[10] Stage 6: *Moderately Severe AD – Level E*: Fecal incontinence

[11] Stage 7: *Severe AD – Level A*: Speech limited to approximately six words on average per day

[12] Stage 7: *Severe AD – Level B*: Intelligent vocabulary limited to generally a single word per day (e.g., Yes or No)

[13] Stage 7: *Severe AD – Level C*: Ambulatory ability is lost

[14] Stage 7: *Severe AD – Level D*: Ability to sit up is lost (brace is needed)

[15] Stage 7: *Severe AD – Level E*: Ability to smile is lost, but may grimace

[16] Stage 7: *Severe AD – Level F*: Ability to hold head up is lost (requires a head brace or is fully bed-ridden)

(Source: Rabins, Lyketsos, and Steele 1999, 14–15)

Potential Causes for AD and Other Cognitive Impairments

Many proposed causes for AD and other cognitive impairments are in the literature, with some causes known through brain autopsies and others through genetic testing. The following causes for AD alone include: 1. Neurotransmitter changes in the brain, 2. Protein synthesis decrease, 3. Accumulation of aluminum in the brain, 4. Polypeptide changes in the brain, 5. Immunity changes, 6. Viruses, 7. Genetics, 8. Brain shrinkage, 9. Formation of plaques and tangles in the brain, and 10. Multiple causes including from the list above (Cohen and Eisdorfer 1986; Petersen 2006).

It is important to continue research into the causes of AD and other cognitive impairments discussed below in the event that an intervention can be discovered that may stop the cause, or even the possible reversal of AD. However, while research continues on the potential for an AD cure, this book and the few like it want to ensure as high a quality of life as possible for those who have AD and other cognitive impairments. Both the physical nature and potential cure for AD research, as well as the cognitive care education research, are important to reach that high quality of life.

Other forms of cognitive impairment include those that are treatable and those that are not. The first group of cognitive impairments discussed here are treatable and thus are important to determine in the event that an intervention is found to alleviate or stop the cognitive impairment. According to Cohen and Eisdorfer (1986), Tripathi and Vibha (2009), and Garfinkel, Illhan, and Bahat (2015), the types of cognitive impairments that are treatable include: 1. Infections (treated with medicinal interventions), 2. Metabolic and nutritional disorders (treated with nutrition and medicinal interventions), 3. Cardiovascular and pulmonary diseases (treated with medicinal interventions), 4. Structural damages to the brain (treated with medicinal and/or surgical interventions), 5. Visual and hearing losses (treated with medicinal, optometric, and/or audio based interventions), 6. Depression (treated with medicinal or psychological/counseling interventions), 7. Reactions to medication (treated by avoiding polypharmacy and through medication psychoeducation and management), and 8. Poisoning (generally treated by extinguishing exposure to the poison).

Based on the above list, it is important to have a physician (M.D. or D.O., or M.B.B.S. internationally) assess the individual with cognitive impairment to rule out the possibility of a treatable case. If a physician can determine that the cognitive impairment may have a treatment, then the need for cognitive impairment care may be minimized and eventually alleviated. If there is not a treatment or cure (e.g., cardiovascular medicine for multi-infarcts that may stop), then the need for determination of AD or other non-treatable cognitive impairments is next.

In addition to AD, other non-treatable cognitive impairments include the following, as noted by Petersen (2006, 110): 1. Frontotemporal dementia (FTD) that is similar to AD with executive skills diminished and 2. Creutzfeldt-Jacobs disease that is fast acting and includes problems with muscle coordination, personality changes, blurred vision, and unusual sensations. Mace and Rabins (1999, 288–89) indicate additional non-treatable cognitive impairments include: 3. Huntington's disease, which is genetic, leading to similar AD symptoms, 4. Lewy body dementia that includes "lewy" bodies that disrupt brain functions, 5. Pick's disease that is similar to FTD due to "picks" that form in the frontotemporal part of the brain, and 6. Wilson's disease that is related to copper accumulation in the brain with cognitive impairments similar to AD. Additionally, researchers are now looking into cognitive impairment associated with HIV in older adults (Fazeli et al. 2017).

Again, we stress all cognitive impairments that currently do have a restorative treatment or cure should be thoroughly assessed in the event that some form of treatment is possible. A timely diagnosis may be of great benefit even with irreversible forms of dementia such as AD (Dubois et al. 2016). We will provide AD treatment later in the book, along with appropriate and compassionate care, but emphasize the following in assessing for AD and related disorders (ADRD), with a visit to a physician that includes: 1. Physical exam, 2. Lab tests, 3. Personal and family medical histories, 4. History of medicines and alcohol use, 5. Neurological exam, 6. Psychiatric exam (by M.D., D.O., [M.B.B.S]), 7, Psychological [or

Counseling exam] (by Ph.D. or Ed.D.), and 8. Specialty exams including EEG, CT, PET, and MRI of the brain (Cohen and Eisdorfer 1986, 38–42).

Collaborative CCCC Question

Introduction Question: Please complete the following question to better understand the materials. Each chapter/module will have a question noted at the end to help you better understand the respective materials.

Question: In CASE ONE, we found a solution for Dora and Tom. Indicate another solution if Dora was found to have a treatable cognitive impairment such as multi-infarct, and did not need to go into the cognitive impairment unit.

CHAPTER ONE

LONG-TERM CARE VERSUS ACUTE CARE FOR THE COGNITIVELY IMPAIRED

Chapter/Module Instructor:

Professor – Russell Porter, Ph.D., Ed.D.,

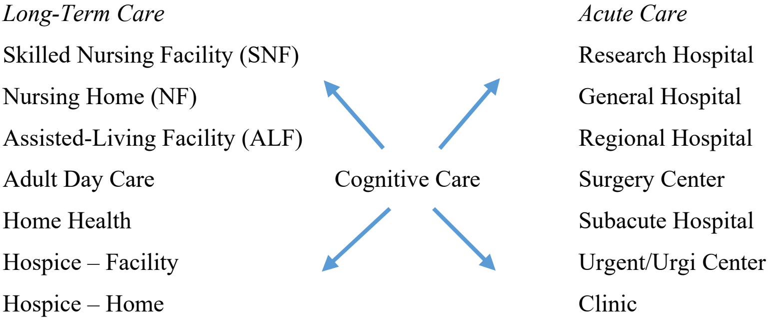
In this chapter we discuss the continuum of care for the cognitively impaired. Your author/instructor was previously a health administrator both in acute care and long-term care, including hospitals, skilled nursing facilities, and nursing homes (without Medicare reimbursement). He teaches health administration at the graduate level and was a licensed nursing home administrator (LNHA) in both New York and Virginia (with both licenses currently inactive). His research in healthcare has focused on the cognitively impaired for nearly 40 years.

A continuum of healthcare can be modeled on "personal services for community health" (White and Griffin 2016, 7), with six primary intervention organizations: 1. Health maintenance organizations such as counseling centers, 2. Primary acute hospitals that provide emergency rooms, medical and surgical suites, with a variation of intensive care and coronary care units, 3. Specialty care organizations such as physical and/or occupational care, 4. Skilled nursing facility (SNF) that must include Medicare reimbursement for skilled care, 5. Nursing homes that do not include Medicare reimbursement and have lower levels of nursing interventions than SNFs, and 6. Palliative care or hospice. As a model to build upon, White and Griffin (2016) provide a good foundation that is focused on the physical impairments more than the cognitive impairments, a model that has dominated since the time of Benjamin Rush in the early 1800s.

Where cognitive care improvements can start to take shape—and with less "littering" on the road to compassionate care—is to take cognitive impairments as a focus instead of the physical impairments; Research indicates that individuals are more fearful of losing mental capacity than diminished physical capacity (Adams et al. 2013). We do not overstress the cognitive compared to the physical, but we want to place cognitive care in the middle of the discussion instead of the physical.

Graph 1 Cognitive Care as Focus of Cognitive Impairments

(Long-Term Care & Acute Care are in order of highest complexity to lowest complexity with highest at top)



Long-Term Care		*Acute Care*
Skilled Nursing Facility (SNF)		Research Hospital
Nursing Home (NF)		General Hospital
Assisted-Living Facility (ALF)		Regional Hospital
Adult Day Care	Cognitive Care	Surgery Center
Home Health		Subacute Hospital
Hospice – Facility		Urgent/Urgi Center
Hospice – Home		Clinic

As an introduction to chapter four with specific long-term care organizations for the cognitively impaired, we discuss here the organizations in Graph 1 and the general approach to cognitive care. We start with a case study to emphasize the use of the entire continuum of healthcare for the cognitively impaired.

CASE TWO: Aging in Place for Mrs. Green

This case takes place throughout the continuum of healthcare with all of the different healthcare organizations involved. We present a short synopsis of the "traditional" model of healthcare, and then we present a synopsis of how it "could have happened" with a more cognitive care approach model. Both models are based on actual cases that have been combined into one case here.

The Traditional Model of Healthcare for Cognitively Impaired

Mrs. Green—as she prefers to be called since she was married for 60 years and states she will never be married again after her husband passed away—was starting to have memory lapses when she was in her early-70s. When she was in her mid-80s, her memory was very short for recent events, but she did remember her time with her husband that spanned from age 19 until she was 79.

Mrs. Green was assessed for AD at age 73, and it was determined that she had both AD and a mild form of Parkinson's that kept her from going *out in public since she was very shy throughout her life. Her husband was nearly the same age as her and was a salesman for a pharmaceutical company for 40 years, and therefore he knew most of the AD and Parkinson's drugs that could help his wife.*

As Mrs. Green progressed from mild "forgetfulness" (as most aged adults have from time to time) to a more progressive memory loss, her husband had her enrolled in a research hospital trial for AD and Parkinson's treatments. Since Mrs. Green was shy, her husband had a home health agency provide her with support on a 12-hour basis every day. She was provided with all the best in therapies, including physical and occupational, to help with her piano playing that was becoming more difficult.

Over a span of five years, Mrs. Green was in research hospitals, a general hospital to fix a broken leg she endured when she fell (it is difficult to determine if a fall occurs, resulting in a broken leg, or if the leg breaks and then a person falls), and in a subacute hospital for short periods of time to regulate her research meds. At one point, Mrs. Green was in ten different studies to determine which medicines could help with her AD and Parkinson's.

In the last five years of Mrs. Green's life after her husband had passed away and she had only one son who lived locally to help her, she spent her time in a nursing home that provided care to all types of residents (patients go to hospitals, and residents "live" in nursing homes). As she aged in those five years, her AD was quickly moving from the moderately severe to severe, and her Parkinson's kept her from interacting with the other residents—thus she spent most of her time in front of the television watching her favorite "Bonanza" program reruns.

In the last month of Mrs. Green's life, she was turned every two hours by the nursing home staff, and they did their best to keep her from having decubiti or "bed sores." Unfortunately, Mrs. Green went from 120 pounds to less than 90 pounds in her last month, and she was moved to a regional hospital in her last week of life. She spent seven days in the regional hospital, and went into the ICU the last day of her life. Her medications were stopped and her son had her placed on a respirator for 24 hours until it was evident she would not live without it (her son was her guardian). Surrounded by only her son and the nursing staff, Mrs. Green was taken off the respirator and she passed away without pain due to the morphine drip she was on.

The Cognitive Care—Compassionate Care Approach

The following indicates that the "traditional" approach may be compassionate, but there is a way to be "most" compassionate based on a cognitive care approach. As Mrs. Green was assessed by both a geriatrician (physician educated on elderly issues), and a gerontologist (individual educated at the doctorate level on elderly issues), she was kept to a minimum of two studies for her AD and Parkinson's. It was stressed by the geriatrician and gerontologist, that "trials of AD and Parkinson's" are ongoing and that no one person should ethically bear the brunt of so many trials. Also, Mrs. Green was provided with only the medications needed to help her with her physical impairments, and only one AD and one Parkinson's drug at a time.

When Mrs. Green was needing therapies, she was indeed provided with the very best, but it was for only short periods of time as was noted by her geriatrician, and with occupational therapy as the prime intervention to help her with her piano playing. Mrs. Green continued playing the piano every day until her last day on earth.