Cleveland Clinic

Center for Continuing Education

Outcomes Study

Dementia 2019: Managing a Public Health Crisis

May 31 and June 1, 2019

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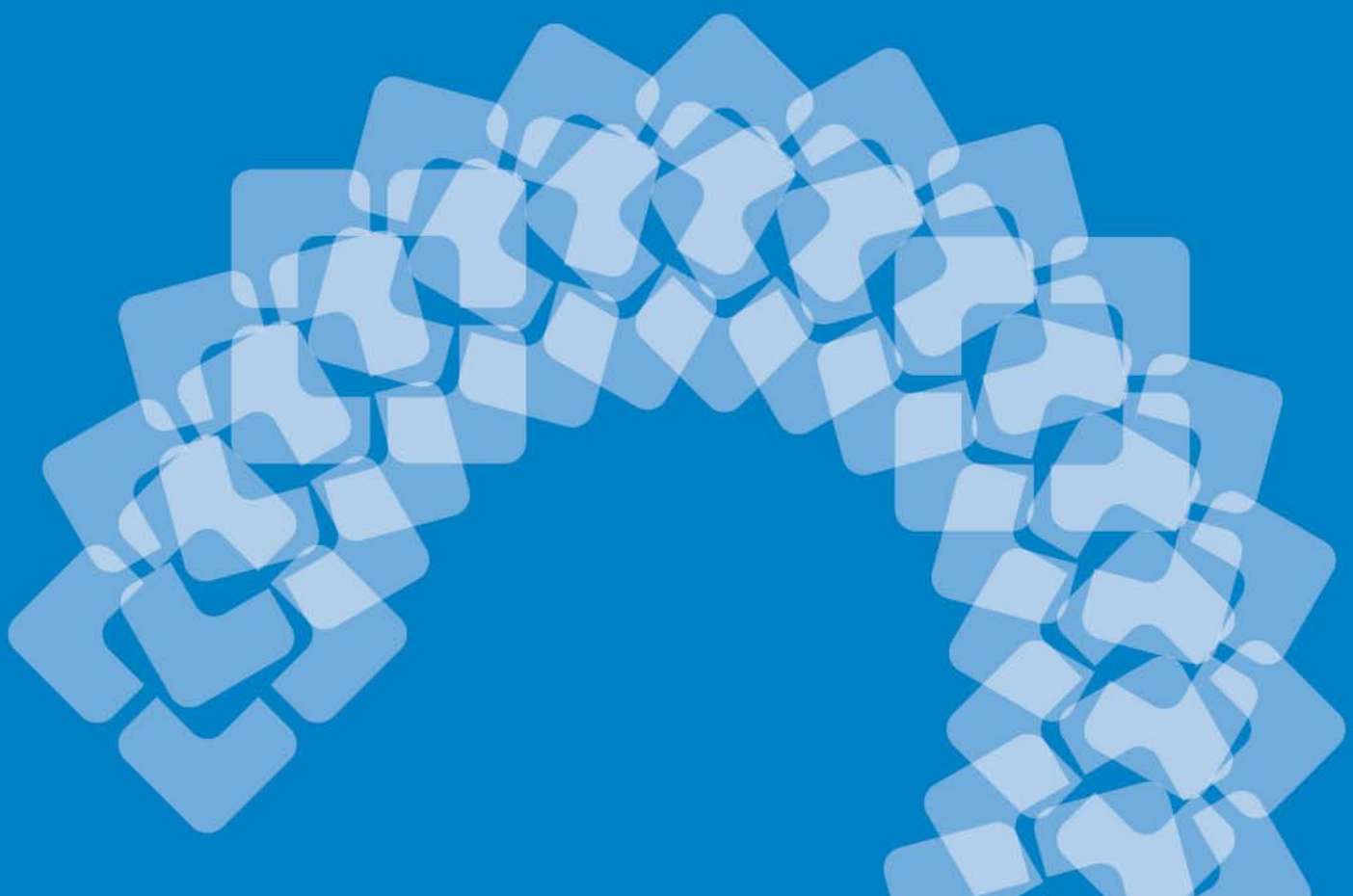

EXECUTIVE SUMMARY

Overview. The Cleveland Clinic Center for Continuing Education and the Cleveland Clinic Lou Ruvo Center for Brain Health conducted an outcomes study to assess knowledge and competency gains and changes in clinical practice behaviors — levels 3, 4, and 5 on Moore's 7 levels of CME outcomes measurements — resulting from participation at the CME-certified live conference entitled, ***Dementia 2019: Managing a Public Health Conference***, on May 31 and June 1, 2019. This two-day conference will alert regional health care providers and social workers to the challenges faced by the elderly in our communities, particularly when they are afflicted by dementia. Evidence indicates that certain lifestyle factors experienced by the elderly, like depression, isolation and sedentariness can actually exacerbate dementia. Over the past 20 years, scientists have investigated proactive strategies as potential protective influences against cognitive decline and dementia. Social engagement, physical activity, cognitive training, and dietary modification are among the potentially beneficial approaches to mitigate cognitive decline. A delay in onset of dementia by just a few years has the potential to dramatically reduce its prevalence.

Methods. Outcomes were measured using five survey tools: (1) Pre and post-conference quiz of 22 questions posed by presenters using an Audience Response System [Pages 7-9]. In 22 out of 22 questions, the audience showed gains in knowledge. (2) Faculty were evaluated post-conference, rating them on content, delivery & visual aids, and free of commercial bias factors [Pages 6-7]. (3) A 12-question evaluation survey post conference that asked clinical practice questions (knowledge gains, competency, overall opinion of activity, etc.) The evaluations were given out at the end of the meeting, and out of the 164 participants, 138 evaluations were submitted to assess the faculty and the conference. Unanswered questions on evaluations were not included in the analysis of this report to account for the percentage of audience responses.

Results. The symposium successfully achieved a measurable impact on levels 1 through 5, as evidenced by the following:

Level 1 – Participation: A total of 185 registrants (164 participants) and 9 faculty presenters in health care participated in this event. MD(50), MSW (21), PhD (11), LSW (10), APRN (8), PT (8), DO (7), MSN (7), BS (6), BSN (6), LCSW (6), N/A (4), PA-C (4), BA (3), DPT (3), MA (3), MS (3), NP (3), RN (3), MBA (2), OTR-L (2), PTA (2); ACNP, ANP, Dip, DNP, EDD, FNP, FNP-C, JD, LPN, MeD, MPA, MPT, PA – (1) each.

Level 2 – Satisfaction: Participants overwhelmingly rated presentations as being excellent, met expectations, was free of bias, and content was between 25% and 75% new for most participants.

Level 3 – Declarative knowledge: The symposium was successful in meeting the learning objectives, and thus, addressed the knowledge and practice gaps identified in the needs assessment. Furthermore, the symposium successfully closed those knowledge gaps as evidenced by knowledge gains in participants from pre-activity to post-activity.

Level 4 – Procedural knowledge: The symposium substantially increased participants' competencies to care for patients affected by isolation, abuse, depression and anxiety and showed proactive strategies for recognizing and forestalling dementia. In addition, nearly all participants indicated that they were likely to change at least some of their clinical practices based on the symposium information.

Level 5– Performance**:** A post-conference survey will be emailed three months after the conference to rate the change in clinical behaviors via an anonymous online survey. Questions to be asked are included at the end of this report, as well as statistics gathered from survey participants.

Conclusion. The symposium effectively improved participants' knowledge, competencies, and self-reported practices to be more aligned with current data and recommended practices, thus achieving outcomes levels 1 through 5. This achievement, in turn, has the potential to improve outcomes for patients with dementia.

INTRODUCTION

The Cleveland Clinic Center for Continuing Education conducted an outcomes study to assess knowledge and competency gains and changes in clinical practice behaviors — levels 3 and 4 on Moore's 7 levels of CME outcomes measurements[1] — resulting from participation at a CME-certified conference on internal and external assaults to the brain, which can cause dementia. The conference, entitled Dementia 2018: Dementia Capable Communities, was held on Friday May 31, and Saturday, June 1, 2019 in the Cleveland Clinic Lou Ruvo Center for Brain Health, Keep Memory Alive Center. The Course Director was Dylan Wint, MD, staff neurologist at the Lou Ruvo Center for Brain Health, Cleveland Clinic.

Goals and Objectives

Upon completion of the program, the clinician/practitioner should be able to:

1. Recognize symptoms of isolation, neglect, depression and abuse among the elderly.
2. Identify proactive opportunities for brain health.
3. Apply best practices in diagnosing and/or treating persons with dementia.
4. Implement methods to preempt dementia complications.

Materials and Methods

Outcomes were measured using four survey tools (all are presented in the appendix):

1. Pre and post-conference quizzes of 6 Day 1 questions and 16 Day 2 questions posed by presenters using an Audience Response (polling) System. In 18 out of 18 questions, the audience showed gains in knowledge.

2. Faculty were evaluated immediately after the conference, rating them on content, delivery & visual aids, and free of commercial bias factors.

3. A 22-question (plus faculty) evaluation survey post conference asked clinical practice questions (knowledge gains, competency, overall opinion of activity, etc.).

1. Moore DE Jr, Green JS, Gallis HA. Achieving desired results and improved outcomes: integrating planning and assessment throughout learning activities. *J Contin Educ Health Prof* 2009;29(1):1-15.

LEVEL 1: PARTICIPATION

The number of physicians and others who participated in the CME activity.

There were 185 course registrants. During the conference, 164 attendees and 9 faculty presenters participated in the program.

The course was successful in attracting the target audience — primary care providers, neurologists, geriatricians, psychiatrists, internal medicine providers, physician assistants, nurse practitioners, long term care administrators, psychologists, social workers and other health care professionals who treat patients with dementia.

In terms of geographic reach, 90% of registrants were from the targeted region of Nevada (128), California (22), Arizona (11), Utah (4), and Oregon (1). Other parts of the country were also represented: Ohio (3); Tennessee, New York, Missouri, North Carolina– (1) each.

LEVEL 2: SATISFACTION

Degree to which the CME activity met participants' expectations regarding the setting and delivery of the information.

A total of 138 participants (84% response rate) completed the activity evaluation form, which contributed to the data for this section. Unanswered questions on evaluations were not included in the analysis of this report to account for the percentage of audience responses.

Table 1. Participant activity evaluations – Day 1

Criteria	Response
Program overall free from commercial bias	100%
How much of content was new?	
Almost all	2%
About 75%	4%
About 50%	41%
About 25%	43%
None	10%
Would you recommend this conference to a colleague?	98%
Compared with other CME activities, this activity was:	
Better than average	80%
Average	19%
Below Average	1%

Table 2. Participant activity evaluations – Day 2

Criteria	Response
Program overall free from commercial bias	100%
How much of content was new?	
Almost all	8%
About 75%	22%
About 50%	48%
About 25%	20%
None	2%
Would you recommend this conference to a colleague?	100%
Compared with other CME activities, this activity was:	
Better than average	97%
Average	3%
Below Average	0%

A total of 138 participants (84% response rate) completed the faculty evaluation form, which contributed to the data for this section. Unanswered questions on evaluations were not included in the analysis of this report to account for the percentage of audience responses.

Summary – Level 2

- Most participants indicated that the faculty talks were well presented and their content material was excellent.
- All Participants noted that the presentations, overall, were free of commercial bias.
- Approximately 63% of participants indicated that at least half of the material was new to them.
- 99% of participants would recommend this educational activity to a colleague.
- 89% of participants stated that compared to other CMEs, this activity was better than average.

LEVEL 3A-3B: KNOWLEDGE

Degree to which participants state what the CME activity intended them to know.
Degree to which participants know how to do what the CME activity intended.

Table 3. Percentage of correct answers to the Audience Response System questions. Knowledge gains were measured by comparing scores on pre-activity and post-activity.

Question Posed	% of Correct Answers Pre-Test	% of Correct Answers Post-Test
1. True or False. Due to many risk factors, social isolation is considered to be part of the normal aging process. a. True **b. False**	77%	95%
2. True or False. Experiencing loneliness is associated with a reduction in lifespan equivalent to smoking 15 cigarettes a day. **a. True** b. False	98%	100%
3. True or False. Family members are more likely to commit abuse/neglect on seniors than paid caregivers. **a. True** b. False	90%	95%
4. True or False. If you have been designated as someone's Power of Attorney, you can prevent them from going and spending all their money at the Casino. a. True **b. False**	81%	92%
5. What is the best treatment for psychotic depression in elderly? **a. ECT** b. Antidepressants only c. Antidepressants plus antipsychotics d. Psychotherapy	8%	95%
6. When present, which of the following is associated with an increased risk of Alzheimer's disease in a depressed patient? a. Functional impairment b. Isolation **c. Cognitive impairment** d. Co-morbid Anxiety disorder	32%	78%

7. Neuroplasticity in the brain involves which of the following mechanisms? a. Neurogenesis b. Synaptogenesis c. Dendritic sprouting d. B and C **e. All of the above**	72%	95%
8. True or False. Computer based cognitive games have not shown beneficial effects. a. True **b. False**	80%	95%
9. Which of the following is an example of the neuroplastic changes that are associated with the principle of specificity? **a. Cerebral angiogenesis with aerobic exercise** b. Increased motor representation with strength training c. The more difficult the training the greater the plastic changes d. Synaptogenesis with aerobic exercise	39%	82%
10. True or False. There is early evidence showing an inverse relationship between long term aerobic exercise and each of the following: cerebral beta-amyloid, tau, and memory impairment **a. True** b. False	88%	97%
11. True of False. Existing treatments have significant efficacy at improving symptoms and address underlying diseases with Alzheimer ’s disease. a. True **b. False**	57%	92%
12. What percentage of patients clinically diagnosed with probable AD during their lifetime did not have AD pathology at autopsy? a. 40% b. 33% **c. 25%** d. 75%	29%	94%
13. Which of these is NOT a non-modifiable risk factor for cognitive decline? a. Age b. Apolipoprotein E genotype **c. Food Allergies** d. Genetic Influences e. Female Gender	49%	97%
14. The higher the proportion of Monounsaturated Fatty Acids (MUFAs) in a diet, the lower the risk for: a. Anemia **b. Coronary Heart Disease** c. Kidney Stones d. Palantir Fasciitis	89%	98%
15. What influences the human gut microbiome? a. Diet b. Smoking c. Medications d. Stress **e. All of the above**	95%	100%

16. True or False. The traditional western diet leads shifts the gut microbiome to an increase in Firmacutes species, which is overall anti-inflammatory. a. True **b. False**	65%	95%
17. The most common cause of dementia in individuals under 65 years old is: **a. Alzheimer's disease** b. Frontotemporal degeneration c. Alcohol misuse d. Lewy body disease	17%	97%
18. Alzheimer, Lewy, and cerebrovascular diseases account for: a. More than 50% of late-onset dementias, but less than 50% of young-onset b. More than 50% of young-onset dementias, but less than 50% of late-onset **c. More than 50% of both young-onset and late-onset dementias** d. Less than 50% of dementia cases overall	31%	92%
19. Which medication is approved in the United States for the treatment of a neuropsychiatric symptom of dementia? a. Citalopram b. Risperidone **c. Pimavanserin** d. Donepezil e. Lamotrigine	8%	84%
20. What region of the brain is most likely to be affected early in the behavioral variant of frontotemporal dementia? a. Left frontal pole **b. Right orbitomedial** c. Right parietotemporal junction d. Left amygdala e. Left insula	14%	76%
21. What percentage of people would want to know if they have a dementing disorder? a. About 20% b. About 40% **c. About 80%** d. About 100%	29%	90%
22. In individuals seeking evaluation, what are the effects of a diagnosis of dementia on depression and anxiety levels? **a. Both depression and anxiety improve** b. Depression improves but anxiety increases c. Depression worsens but anxiety lessens d. Both depression and anxiety worsen	17%	90%

Learning objectives. Knowledge gains were also measured by participants' evaluation of learning objectives met (Table 3). These objectives directly correlate with the faculty presentations. The learning objectives were selected to address the knowledge, competency, and practice gaps identified in the educational needs assessment conducted at the proposal stage.

Table 4. Participants' rating of learning objectives met on course evaluations – Day 1

Learning Objectives		

1) Recognize symptoms of isolation, neglect, depression and abuse among the elderly.	100%	0%

Table 5. Participants' rating of learning objectives met on course evaluations – Day 2

Learning Objectives	Met	Unmet
1) Identify proactive opportunities for brain health.	100%	0%
2) Apply best practices in diagnosing and/or treating persons with dementia.	100%	0%
3) Implement methods to preempt dementia complications.	99%	1%

Summary – Level 3

- Pre-Test/Post-Test: Improvements in knowledge was demonstrated in 18 out of 18 faculty questions posed.
- Learning Objectives Day 1: 100% reported that recognition of symptoms of isolation and neglect were met.
- Learning Objectives Day 2: 100% reported that identifying proactive opportunities for brain health was met, 100% reported that determining opportunities for best practices in diagnosing and/or treating persons with dementia was met, and 99% reported that summarizing ways to preempt dementia complications was met.

LEVEL 4: COMPETENCE

Degree to which participants show in an educational setting how to do what the CME activity intended them to be able to do.

Results from the CME evaluations provide further evidence of this activity's potential impact on patient care. A total of 91% indicated that they were likely to make a change in their practice behavior based on the information learned at the course; 78% were likely or very likely to change (Table 4).

Table 5. Intent-to-change practices.

As a result of what you have learned in this activity, will you change your practice behaviors?		
	Response rates – Day 1	**Response rates – Day 2**
Very likely	55 (43%)	56 (43%)
Likely	48 (37%)	49 (37%)
Somewhat likely	21 (16%)	19 (15%)
Not at all	2 (2%)	2 (2%)
N/A	2 (2%)	5 (4%)

Number of patients to be affected by these changes each month – Day 1:	>50	41-50	31-40	21-30	11-20	1-10	0	N/A
Number	18	7	7	6	23	53	5	15
Percentage	13%	5%	5%	4%	17%	38%	4%	11%

Number of patients to be affected by these changes each month – Day 2:	>50	41-50	31-40	21-30	11-20	1-10	0	N/A
Number	19	8	8	9	26	44	4	6
Percentage	15%	6%	6%	7%	21%	35%	3%	5%

Changes in Patient Care – Day 1:	Significant Effect	Some Effect	Minimal Effect	None	N/A
Number	34	75	2	0	3
Percentage	30%	66%	2%	0%	3%

Changes in Patient Care – Day 2:	Significant Effect	Some Effect	Minimal Effect	None	N/A
Number	38	79	3	0	5
Percentage	30%	63%	2%	0%	4%

Participant's clinical practice behaviors proposed to change:

Day 1

1. Be more proactive in encouraging changes in small steps
2. Be more vigilant with asking questions of patients regarding depression, loneliness, isolation, community involvement
3. Be more aware of screening for and attending to social isolation/loneliness
4. Emphasize need for socialization/interaction opportunities
5. Consider vascular depression and assess for it. In addition to other etiologies. Consider depression as a cause for medication and/or treatment non-compliance.
6. Prioritize brain health
7. Can advise clients as to the wide range of available treatments for depression, especially ECT for psychotic depression.
8. Use some measures already but try certain new depression screen tools
9. Will focus on assessment for depression in elderly - provide for annual activation for ong-term patients to improve interaction and decrease social isolation
10. Screening tools/strategies, expanded ideas of what to look for/ask about
11. Screening
12. Developing a screening tool to use with adult endo and sleep med.
13. Not questioning depression and loneliness
14. More attuned to elder depression
15. I will pay more attention to possible burnout in myself and other colleagues. I will also be more engaging and direct.
16. Better diagnosis - right medication. Good communication with medical professional.
17. Increase awareness of social issues
18. Review of potential neglect, loneliness, dementia and depression scale

19. More active referral to support care
20. Not relevant
21. Start using the CTDS more than PHQ-9 in my geriatric patients.
22. Increased awareness to ask more questions
23. Be more encouraging in scheduling geriatric patients and community services
24. Provider education for assessment and resources
25. Awareness; General social interactions
26. Depression screening
27. Always get collateral info from caregivers; not to under report to EPS even if you think you do not have enough info
28. Revising questions I ask, actual looking in fridge and cabinets, review conditions often
29. Find resources
30. Very likely if I know the resources
31. Increase in awareness in order to better identify social isolation importance of watching for self-neglect for caregivers too!
32. I practice SW in a hospice setting. Caregiver burnout was most relevant.
33. Learned a great deal about loneliness and its impact
34. Address loneliness with patients and caregivers
35. I plan to slow down and take my time to asses vs. rushing.
36. Engage family and participate
37. Ask more about depression and isolation; resources to keep
38. I will be more proactive in finding community resources to share with my patients to help prevent social isolation.
39. Referral to MSW in home care
40. Provide patients access to available resources
41. I need to focus more during my interview on loneliness
42. I will begin to use the Cornell scale for depression in addition to the DHQ-9 I already use
43. But I will change is some of personal practices - be more aware of socially isolated persons, perhaps even explore activities for volunteerism
44. Issues of isolation/depression well more likely to ask or speak to clients about these issues.
45. Reporting to EPS
46. Paying attention to the lonely
47. Identify a disability community
48. Will ask more questions to assess for loneliness, neglect, depression

Day 2

49. Assessment for AD, Lewy Body
50. Educate our patients on the importance of exercise.
51. Embracing the awareness of all aspects that involve dementia i.e. diet, social aspect, exercise.
52. Specific interview and assessment techniques, referrals for treatment.
53. Change or improve and be more faithful to exercise and healthy eating.
54. Provide more resources to patients. Increase education to patients. Increase my own research initiatives of above topics.
55. More discussions on loneliness.
56. Will increase screening and sensitivity to patient's presentation and patient needs for possible dementia. On temporary (1 year) sabbatical.
57. Interviewing and screening.
58. Confidence increased to answer questions related to illness in the elderly population.
59. I'm not sure if my organization will accept a radical change, based on the cost of implementing these changes.
60. Increase exercise and dietary advice.

61. More proactive with dementia screening for dementia in elderly depressed patients.
62. Be persistent with change.
63. Keep dementia diagnosis in mind when working with patients who may exhibit sign and symptoms that could be due to other conditions.
64. More screening- use of biometric markers- consider additional differential diagnosis- emphasize prevention!
65. Better screening. Differential diagnosis skill.
66. Encourage the standard- exercise, healthy eating, etc.
67. Emphasize physical activity, healthy diet measures during office visits.
68. Use of exercise.
69. Focus on what I can do more with Alzheimer's.
70. Time spent with elderly/senior that are lonesome.
71. Emphatic approach to.
72. Check markers for dementia for diagnosis.
73. Consider ordering PET scan.
74. Will advise clients to take into account diet and exercise. Social interactions when they suspect memory issues.
75. But I'll change my behaviors- especially diet.
76. Diet and exercise education for patients and caregivers.
77. Improved screening or diagnosis.
78. Screening tools.
79. Differ my approach to testing with cognitive deficits. Have better information to inform patients about supplements.

Suggestions for future topics / Other comments:

80. Nevada outpatient resources that are available so that patients don't have to be legal zoo to get services or meds; alcohol/wernicke korsakofs; appetizers and wine was great
81. Better chairs; fewer breaks
82. A list of local resources for respite care/caregivers support would have been helpful
83. Advances in neurological diseases - research, treatment, medications.
84. Venue: Chairs were a little hard and uncomfortable, beautiful and accommodating venue, need more plug in access for laptops, etc. Future topics: use of modalities, kinesiology, new info on new topics (CVA, TBT, etc)
85. Jason Cheng, DO's presentation was likely more "practical" for those directly in mental health.
86. Health provider burnout and nutrition in mental health
87. How to best handle dementia with behaviors
88. Dr. Chan you did a great job. There is ample reason aforementioned to develop more talks (albeit time consuming!!) Your delivery smooth and voice easy to understand.
89. Continue to provide wages for government agencies to better engage and make positive care and treatment and supportive services to the Vegas community.
90. Include specific information re: cognitive impairment and how, why, when to assess it.
91. Dealing with dementia in primary care
92. Dr Cheng: his prevalence reference is between 2008 to 2009 time periods; this is the period that America suffered from great financial problems due to housing crash. Therefore, prevalence maybe skewed. I'm wondering if the prevalence reference that is correct would be the same.
93. I like the speaker in the bathroom so nothing is missed from presentation
94. Navigating the VA system for social workers; Ruth Almen LCSW should give many, many more presentations. Great job.
95. Best CME I have attended! Came all the way from NC, was worth it! Thank you!
96. Send out email about printing presentations earlier than one day before conference, consider purchasing more comfortable chairs, consider having 1/2 day conferences

97. Guardianship- when to apply and how; long term care options in Nevada
98. Office evaluations to assess dementia and players; family education reason "what do I tell the spouse and children"; medical causes and change in mental states and depression treatment; to hospitality more to traditional care; change the chairs
99. Speaker for the EPS program on how it works. Follow ups and repeat. Legal issue with regards to elderly abuse.
100. A talk on how to build a psychosocial tool box of services for providers; Dr. Changs first professional presentation was impressive
101. More case studies would be beneficial
102. Great conference! But the room was freezing.
103. Dementia in relation to people who prefer to live in isolation (monks); snacks were good!!!
104. Very excellent speakers!
105. Displays are too small
106. Resources available in NV; Dementia and Behavioral health practices; caregiving: information for those caring for individuals with dementia; great conference so far, great staff - very accommodating to attendee's needs
107. Missed the printouts, maybe exclude the fun pictures of PowerPoints if to save paper.
108. There should be a lecture on music as a therapy or reaching the dementia patient.
109. Thank you for the great speakers, the great food and beverages, the resources.
110. Loved the speaker's selection and their topics! Great conference! I would absolutely bring a loved one or myself here for diagnosis and or treatment and I live in Ohio!
111. Please include more neuropsychology information.
112. Great! I'll come again! Thanks.
113. Very good conference. I learned so much. I really appreciate the case studies and heavy audience involvement. A good overview of the topics that have been spoken by each presenter.
114. Excellent topics and knowledgeable presenters. Food and drinks wonderful. Great job!!
115. I wish you provided program data as print out like before you have done.
116. For Jason Longhurst- include videos of examples of treatments; exercises and practical application- a little too heavy on graphs and studies of rats, etc. Dr. Sabbagh- great speaker, the diet talk was most helpful. Dr. Ritter- using case studies was very helpful.
117. Dementia relates to alcohol. Narcissism, could this be dementia? Food was excellent!
118. Awesome lunch menu! With "dry" content use joke, cartoon, story or case study.
119. Excellent conference. I think more case-based presentations would improve audience involvement and learning. Loved the venue. I look forward to another conference here!
120. Love it! Thank you!
121. Great conference!
122. My 3rd year of attendance and these seminars are excellent!
123. Handling behaviors in Alzheimer's.
124. Absolutely outstanding in all aspects. I will bring this information back to my colleagues and recommend this conference to them. Thank you! Rebecca A Seelinger FNP-BC, Sedalia, Missouri.
125. Main takeaways, particularly towards clinical practice, were very helpful and should be incorporated as much as possible.
126. Inclusion of takeaways for every presentation. Maybe even include ways to integrate into clinical practice immediately (suggestions for how to take what is presented and translate to all clinical practices, not just for primary care physicians).
127. A lot of medical terminology used throughout, very difficult to follow some presentations.
128. Legality, some dealing with dementia/caregiver i.e. applying guardianship.
129. Prepare a survey for practitioners on Alzheimer's disease.
130. Presenters have very good, excellent delivery. The visual aids very helpful. Recommend laser pointers to highlight specific information in diagrams. Thank you for an educational and meaningful learning experience.

131. Great conference! I learned a lot!
132. Suggested speakers in addition to Dr. Sabbagh and Dr. Wint: Dr. Jeffrey Cummings, Dr. Ronald Peterson (re MRI), Dr. Peter Nelson (re LATE/CARTS + PART).
133. Connect medical and social services. Community and program influences on medical media.
134. Excellent content!
135. Excellent conference!
136. Very good course.
137. In AAFP we have a Q&A with multiple MDs and faculty so they all have a chance to comment/answer questions.
138. Invite Katie Boer (former KLAS-TV) as speaker. She did Dementia Diaries as a news special.
139. Topic: Alcohol and cannabis use/abuse in elderly.
140. Lunch was excellent. Thank you.
141. Some slides difficult to see and impossible when printed out from downloads.
142. Please encourage presenters to have less text on slides.
143. Enjoyed Dr. Wint's sense of humor!
144. Enjoyed case-based talk over more "data" driven presentations.
145. The neuropsychology of dementia.
146. As a way to connect with other attendees, maybe put <where from> on name tags? I came alone and from outside NV. So was more challenging to connect with others.
147. I have been to several CE courses here. They are great. Please go back to providing the slides in a booklet. I am happy to pay another $5-$10 for the course to have the materials on hand upon arrival. I either never got or never saw the email for the pre/posttest and course material.
148. Assistance programs for caregiver burnout. The food was excellent.
149. I really enjoyed the information and the content. I do feel that it was slightly medical which is not entirely relevant for outpatient are which is my setting predominantly.
150. Whatever Dr. Sabbagh wants to talk about. I could listen and learn from him all day!
151. Since we have done a better job caring for the mentally ill, they are now living to old age and now have mental illness AND dementia. This can have its own special clues (much like Down's syndrome) maybe a talk on "special groups with dementia". This is my 3rd year coming to this. Sign me up for next year (It is time and money well spent)!
152. Lunch was excellent especially following presentation about diet!
153. Consistently pertinent and educational information presented. Well organized. Speaker superb!
154. Differences between various forms of dementia.
155. CTE. How treatment of Lewy Body vs. Vascular Dementia vs. Alzheimer's disease vary? Migraines/headache (chronic) Pathology and treatment. There are a great deal of studies cited but no all speakers provide a reference page… There are several studies I would like to read. Thank you!
156. All presenters were excellent- very knowledgeable and good speakers/presenters of their information. Appreciated the practical information tied to study results (rather than just rattling off data seen in some seminars). Enjoyed Dr. Wint's jokes as well!
157. Some speakers left too soon, did not stay after their talk. At least to stay through the break.
158. Alzheimer's specific topics for healthcare providers.
159. Support centered topics when diagnosed with a cognitive/memory impairment (caregiver support resources, healthcare provider resources).

Summary – Level 4

- Symposium increased participants' confidence in earlier diagnoses and support for both patients and caregivers
- Nearly all participants indicated intent to change their clinical practice behaviors based on the information learned.

LEVEL 5: PRACTICE

Degree to which participants demonstrate a change in practice behaviors. **Dementia 2019: Dementia Capable Communities – 3-Month Post-conference Evaluation** (Early Sept. 2019)

Q1: As a result of attending the conference, have you changed your practice behaviors?

Answered: 31 | Skipped: 0

Answer Choices	Responses
Yes, Consistently	32.3%
Somewhat	67.7%
Neutral	0%
Not at All	0%
Total	100%

Q2: As a result of attending the conference, has your confidence in Patient Care increased?

Answered: 31 | Skipped: 0

Answer Choices	Responses
Yes, Consistently	54.8%
Somewhat	41.9%
Neutral	3.2%
Not at All	0%
Total	100%

Q3: As a result of attending the conference, how much of an effect has there been in changing Patient Care?

Answered: 31 | Skipped: 0

Answer Choices –	Responses –
Significant Effect	16.1%
Some Effect	83.9%
Minimal Effect	0%
None	0%
Total	100%

Q4: As a result of attending the conference, what Clinical Practice Behaviors have changed?

Answered: 20 | Skipped: 11

- Understanding that diagnosis is a complex process most competently managed by a multidisciplinary team and a Neuropsychologist whenever possible
- Listen more carefully from pt and family members

- Attention to isolating behaviors
- Empathy, understanding
- More conscientious of approaches
- Better at picking up first signs of dementia and therefore being able to be more proactive with the patient and family.
- Client assessments
- Reemphasize the importance of lifestyle modification and healthy diet plan
- More MMSE
- Screening and evaluation of dementia
- Screening for Suicide and Increased Education re: Social Isolation
- Interviewing clients is more personal and compassionate. More positive, encouraging and supportive. I have more current information and options to offer clients.
- More aware of some possible considerations for clientele!
- More attention when working with a person with cognitive impairment.
- Trying to decrease patients social isolation and loneliness.
- Encouraging lifestyle changes to reduce dementia risk.
- dealing with patients' behaviors
- Even more encouragement to exercise.
- Referral to social services are more of a priority
- Diagnosis and counseling with more confidence

Q5: As a result of attending the conference, approximately how many patients have been affected by these changes?

Answered: 31 | Skipped: 0

Answer Choices	Responses
0 - 25%	48.4%
25 - 50%	29%
50 - 75%	16.1%
>75%	6.5%
Total	100%

Q6: What were the MOST effective aspects of attending the Dementia 2019 Conference?

Answered: 23 | Skipped: 8

- Understanding the research
- Prevention and diagnosis
- The role and impact loneliness plays on overall health
- Information presenters shared.
- New research
- Understanding differences between dementias
- Understanding the dementia process
- The section on drugs being tested and also what has failed.
- I am only able to say that there were aspects of several discussions that have combined to assist me. I did particularly enjoy the overview of the chairman.

- New information/studies
- Good speakers
- Just receiving the knowledge at an advanced level.
- Better understanding of loneliness
- 2019: Increased awareness around social issues. Also diet and exercise component was excellent
- The information from experts who practice; networking, the services presented with informational handouts and resources. The excellent lunch!
- New assessments and considerations, healthy diets
- Excellent speakers
- Learning about the new progress in Alzheimer's research and ways to help patients
- Hearing current thoughts on the etiology of dementias, drug development
- I was at Dementia 2019; most useful piece was distinguishing between the types of dementia.
- Variety of topics related to dementia, differential diagnosis & case studies
- Motivation to continue discussions with families and caregivers

Q7: What were the LEAST effective aspects of attending the Dementia 2019 Conference?

Answered: 19 | Skipped: 12

- None
- Some lectures were confusing
- I live in Sun City Anthem, an affluent community, and have come across a number of elderly whom have shared at which stage of debility they plan to end their lives in the future. These are college-educated, middle-class senior citizens with a plan to maintain their dignity and independence and end their lives when this quality of life is no longer possible. This is a topic that is spoken about in an open yet quiet manner. Most are afraid to become a burden on their families. Worse yet, this is an elderly population whom generally can afford assisted living options but have unhappy friends in these facilities. Their friends complain about the cost, the quality and variety of food served, poor staff training, English proficiency of staff and staff turnover.
- The section on human micro biomes, it was above my level of understanding
- None noted
- N/a
- The PT section needed to be more informative. Maybe some actual treatments that have been effective and some that have not.
- none
- There was none.
- 2019: It was all very good - as a social worker, not every segment related to my work, but seemed very relevant to the medical professionals.
- None (:
- N/A - The conference was amazing!
- The reality of no simple answer for treatment.
- n/a

Summary – Level 5

- Participants felt the conference helped change clinical behaviors 3 months post-conference.