

Female Speaker: Good afternoon and welcome to the second webinar in Alzheimer's disease and related dementia's three-part webinar series. We are pleased that many of you have joined us for today's live presentation of webinar #2 Managing ADRD and Utilizing Available Resources. Please note that this webinar is being recorded and we will share the link with you as soon as it becomes available after today. Also if you have not already done so we encourage you to register for the last webinar in this series. Look for registration detail for the webinar very soon. Today's webinar presentation features Dr. Todd Goldberg, Associate Professor, Chief of Geriatrics, Geriatrics Fellowship Program Director, Department of Medicine at the West Virginia Health Sciences Center, Charleston Division at Charleston Area Medical Center. We will also be hearing from Hanna Thurman, Training and Development Manager for the West Virginia Geriatric Education Center.

Due to the high volume of participants we will keep all lines muted throughout today's webinar and many of you are likely listening through your computer speakers as well. We will be featuring some polling questions throughout the first half of today's webinar. We encourage you to participate in each call if you are able to do so by typing your answer in the chat box feature which is located on the right side of your WebEx player. Finally, so that you have an opportunity to ask questions and share your input we ask that you submit your questions through the chat box feature again located on the right side of your WebEx player. We will get to as many as time allows after Dr. Goldberg and Ms. Thurman conclude their presentation. Again we want to thank you for joining us today and without further ado it's my pleasure to introduce our first presenter for the day, Dr. Todd Goldberg.

Dr. Todd Goldberg: Good afternoon, Dr. Todd Goldberg here again, WV Charleston Division CAMC and West Virginia Geriatric Education Center. Happy to be here and welcome to my discussion of Alzheimer's Disease and Related Dementias or ADRD. First part was the basis of the disease. Second part today is on management for patient and family and caregivers. So we are going to start with caregiver rather than the patient because that's actually the first line we have to deal as they take care of the Alzheimer patient.

First polling Question 1 for Part 2. Who provides most of the care for people with ADRD, Alzheimer's disease and related dementias?

1. Family/lay caregivers.
2. Direct care workers such as home health aides & certified nursing assistants in nursing homes.
3. Health care professionals such as doctors like me and physicians, registered/advance practice nurses or Pas or
4. All of the above.

I would say the correct answer 4, obviously the answer is all of the above, and not in that specific order. So really who takes care of people with Alzheimer's disease and related dementias? Vast majority of the work and time is done by the family or lay caregiver, community and by home and direct care workers and home workers and institution and facility based care and certified nursing assistants and health professionals like doctors, nurses, and PAs, part time nurse practitioners where contact with the patient is really need. So ironically the majority of care

provided by people who may care a lot but actually have a weak knowledge in training, and this care is really hard and stressful. Caregivers really need more training and support.

According to the survey reported by the Alzheimer's Association in 2006 80% of caregivers report that they frequently suffer high levels of stress and nearly 50% report feelings of depression, such feelings of enduring stress and frustration have been frequently referred to as "caregiver burden" or caregiver stress or burnout. High levels of caregiver burden have been shown to lead to a wide variety of negative outcomes for patients, caregivers, and others. Including when caregivers do burn out, will lead to neglect or institutionalization.

Caregivers are often reluctant or unable to voice their concerns to healthcare professionals and you have feelings of obligation, and feel guilty if they don't provide care, but they are forced to take on the "caregiver" role to the exclusion of self-preservation, then you frequently unaware of the toll that caregiving is taking on you. So given the impact of caregiver burden and burnout on both the caregiving individuals and our ADRD patient, it really is incumbent on the health professional to screen for and monitor caregiver burden, along with caring for the actual patient ourselves!

Screening for geriatric care or questionnaire, The Caregiver Burden Inventory (CBI), I am not going to focus on testing and scoring, so here are the five subscale scores.

1. Time Dependency. Caregivers feel like he/she needs my help to perform necessary daily tasks, is dependent on me, have to watch him/her constantly, I have to help him/her with many basic functions , I don't have a minute's break from his/her chores. You can already imagine how stressful it is.

Development items under sub scale, a caregiver may feel like she is missing out on life, I wish I could escape from this situation, my social life has suffered, I feel emotionally drained due to caring for him/her, I expected that things would be different at this point in my life.

Physical Health Items: Caregiver may feel like or actually not really getting enough sleep and her own health might suffer. Caregiving has made them physically sick, physically tired.

Social Relationship Items: I don't get along with other family members as well as I used to. My caregiving efforts aren't appreciated by others in my family. I've had problems with my marriage or other significant relationship, I don't get along as well as I used to with others, I feel resentful of other relatives who could help but do not help.

Emotional Relationship Items: I feel embarrassed over his/her behavior, I feel ashamed of him/her, I resent him/her, I feel angry about my interactions with him/her, I feel uncomfortable when I have friends over. Imagine if your mother came down while you had some friends over. So again if a caregiver feels and reports a lot of these things that's a problem, they need to care for themselves.

The caregiver may even become clinically depressed and you may not be the patient necessarily, and they can briefly treat for depression and consult their own doctor or therapist. You can screen for depression very quickly if you are a patient caregiver, you don't have to do the 30-

point depression scale, you can ask two simple questions or even one. During the past month have you often been bothered by feeling down, depressed, or hopeless? During the past month have you often been bothered by little interest or pleasure in doing things with feelings of depression or anhedonia. If you are concerned about significant depression, considering asking about thoughts of self harm, or harm directed at care receiver. This may be a delicate issue if you are not the provider for the caregiver but you have to bring it up anyway.

Supporting the caregiver: Just asking about burden is helpful, is validating the caregiving experience/role in stress. People want to know if they are doing “enough” or “what they are supposed to be doing”? Are they doing the right thing and reassure them that they doing the right thing and if they need it we refer them to community support resources, psychologist or psychiatrist, PPT, Alzheimer’s Association Support Group and a book called The 36 Hr Day. These are some of the best sources of help for family and caregivers. Ever since my training in the 1980s I have been recommending this book, it's still the best one on the topic that I know of. The 36 Hr Day by Dr. Nancy Mace and Rabins from Johns Hopkins which anyone can get easily from any book center or library, or you can borrow a book for a caregiver who doesn't have the ability or motivation of finding the book, and I myself would give you the way to find listening to audio, also very valuable from the Alzheimer’s Association. So, it will help the family for treatment. The Alzheimer’s association formerly known as the ADRDA Alzheimer’s Disease and Related Disorders Association has a great website, alz.org. you see on the right side, has lot of information both on the website and local offices with support group and even 24 hour helpline and they are invaluable.

Now let’s get back to managing our actual patients with Alzheimer’s disease, managing the ADRD itself and other concomitant medical Problems with complications with all the things listed on the slide. Again managing with person with Alzheimer’s always start with education, education, education for family and caregivers and facilitate access to community resources, local Alzheimer’s Association offices, senior centers, state department or county department of aging, I can't recommend enough of The 36 Hour Day guide for families/caregivers. You also want to look at cardiovascular disease risk factor reduction, we try to minimize vascular dementia, so that means you check blood pressure etc,. and avoid medications/treat illnesses that could impact cognition.

General consideration in managing patients with Alzheimer’s. Remember patients with Alzheimer’s disease are still people, people with Alzheimer’s, we have to treat them like an individual and human being, work to take advantage of strengths and abilities.

The patient should definitely try to stay active and normal as they possibly can. Maintain regular physical activity, social activity, support emotional and spiritual needs, encourage people to continue to do those things they can still do safely.

Now considering specific medications for this condition here is our next polling question: Say you want to give a 70-year-old patient with mild to moderate Alzheimer’s dementia a prescription drug approved for this indication. You will prescribe:

- A. Aricept or donezepil
- B. Razadyne or galantamine

- C. Exelon or rivastigmine.
- D. Any of the above, they are all about the same.

My answer would be D Any of the above drugs are all approved for mild to moderate Alzheimer's and they are all about the same in terms of efficacy. Aricept is the most popular, Exelon is also popular, Razadyne or galantamine doesn't seem to be as popular but it's really just about equal to the others and I will show you a little bit of the effect for each drug.

The FDA medical letter October 2013, list all the FDA approved medications for Alzheimer's related dementia and again really only approved for Alzheimer's disease with the exception of Exelon or rivastigmine which is also approved for Parkinson's dementia. More legibly again these are the FDA approved medications for treatment of Alzheimer's disease or Alzheimer's dementia. Cholinesterase inhibitors and NMDA inhibitors. Cholinesterase inhibitors are for mild to moderate Alzheimer's disease. Aricept is also approved for severe Alzheimer's disease. Exelon patch is also approved for both mild to moderate and severe Alzheimer's disease as well as Parkinson's dementia. There used to be another cholinesterase inhibitor, first one actually from 1990 called THA which is no longer used because it is four times a day and a lot more GI side effects. All these others are once or twice a day at the most and much better tolerated. When Aricept came out, they stopped using THA. Namenda is for moderate to severe dementia either alone or add on to the other cholinesterase inhibitor. At this time, there is unfortunately there is no other drug for Alzheimer's or any other type of dementia or any other spectrum of dementia specifically, and you will see that you really need more treatment, there is no specifically approved or proven drugs whatsoever for Lewy body dementia, vascular dementia, fronto-temporal dementia or mild cognitive impairment which is really a shame. Hopefully we will change it.

Some specifics on each of these drugs. Aricept, the generic name which is donepezil, widely used and advertised and approved for mild-moderate and even severe Alzheimer's disease. Begin 5 mg once a day dose for 4-6 weeks and titrate up to 10 mg daily as tolerated and also there is a 23 mg dose available for severe dementia. Usually well tolerated but some common relatively mild side effects are upset stomach or poor appetite, sleep disturbances, syncope/orthostasis/bradycardia. Watch out for those, and on the lower right is some of the data that is approved which is similar to all the Alzheimer's drug. You will see that dose and efficacy is measured by research only cognitive scale called ADAS-cog. Alzheimer's Disease Assessment Scale, cognitive score scale, it's a 70-point scale test and in the clinical trial of donepezil, patient is given 5 or 10 mg donepezil and had about 2 or 3 point clinical improvement on the scale whereas the patient has decline in cognition for progressive neurodegenerative disease. The difference of about 3 point total between the treatment and placebo group was statistically significant but it's really a rather mild effect, 2 or 3 point o a 70 point scale is really equivalent to about 1 or 2 point on 30 point mini mental status test, so not a very impressive improvement unfortunately.

Similarly Exelon, generic Rivastigmine approved for mild to moderate AD and Parkinson's Dementia and patches are also approved for severe Alzheimer's disease. Originally there were Exelon pills that were titrated up from 1.5 mg twice a day to 6 mg t.i.d. and it had a lot of GI side effects, you don't need Exelon pills anymore, patches are much better, they definitely have much

less GI side effects and begin Exelon patches as pictured on the right, it's 4.6 mg patch, change daily, titrate up in four weeks to 9.5 mg patch, more recently higher dose 13.3 mg approved for severe dementia. Don't ask me why, but similar to Aricept common side effects same, with addition of rash from patches.

Razadyne or galantamine again has similar efficacy is available in short acting or long acting forms in its generic as all the others now, at one patch, they are again titration 8 mg a day to 16 to 24 mg a day and approved for mild to moderate Alzheimer's not severe Alzheimer's, basically should not be used for mild cognitive impairment there is a black box warning of increased death, if used for mild cognitive impairment. Similarly Aricept for mild cognitive impairment, a study that has not shown in terms of progression to full blown dementia. So unfortunately there is no treatment for mild cognitive impairment.

And final drug again, Namenda generic Memantine, approved for moderate to severe Alzheimer's disease, and start with a titration Namenda 5mg twice a day per week and up to 10 mg twice a day is very well tolerated if given alone or in combination with Aricept, very benign product, I haven't seen data, but some people say it may reduce GI side effects of cholinesterase inhibitors, so you can start before or with cholinesterase inhibitor and originally a titration of 5 to 10 mg b.i.d. but a short acting Namenda tablet has actually been discontinued in past year, 2014, and there is a new Namenda XR with a different dosing schedule, 7, 14, 21, 28 mg once a day and of course the new expensive brand of Namenda XR is not available generically which is probably why they introduce it, there is no generic Namenda tablets available now but maybe it will be in the future.

Some of the data from Namenda or memantine, this is the most important study showing Namenda versus placebo and Namenda versus Aricept and Aricept alone and they both led to significant clinical improvement on the test for severe cognitive impairment, in this trial published in JAMA, Journal of the American Medical Association exactly 10 years ago, Tariot et al January 2004, and Namenda plus Aricept was a little bit more effective than Aricept alone. Namenda plus Aricept was the goal standard therapy for moderate to severe dementia but likely the cholinesterase inhibitor alone for mild to moderate dementia, the effects is pretty moderate, so they still really need much better treatment, also much more recent study in New England Journal of Medicine just in the last year or two, actually this time Aricept and Namenda being the same, the combination is no better than either one alone from the stated study, that was pretty disappointing but there is actually no approved Alzheimer's disease drug since then which is over 10 years now, that is a shame.

So, to try improve functioning and perhaps function in Alzheimer's with cholinesterase inhibitors and memantine, we also have to take care of other medical problems, diabetes, hypertension, heart disease, etc., as well as anxiety, depression, and other behavioral and psychological symptoms that often need intervention. Alzheimer's may impact other aspects of care in terms of medication compliance, nutrition and safety. So other conditions/medications that impact cognition need special attention, and in a dementia patient it's even more important to focus on prognosis and goals of care. What are you trying to achieve? What's inappropriate, that may cause blood pressure and diabetes. We may have to err on the side of safety. Diabetes or hypoglycemia more dangerous than modestly elevated glucose, the hemoglobin A1C goal may

be 8 instead of 7 in an average diabetic. Hypertension or orthostatic hypotension and risks of falls are very important with goal systolic blood pressure in frail elderly people even more likely 150 instead of 130 to 140. Again, meds that impair cognition to be avoided, psychotropic drugs all risky and should be minimized, it can cause falls, increased confusion, death. It's often necessary to compromise with once daily regimens to improve compliance. Patient probably won't be able to remove to take multiple doses of a drug a day, or they wouldn't remember to take once a day especially *[Indiscernible]*[00:25:34] caregivers or family should call them once day.

Alzheimer's and depression: People with history of depression/mood disorder may become demented and vice versa. People with dementia not surprisingly frequently become depressed. Perhaps as many as 25% of patients will experience depression during their course. Treatment: Cognitive behavioral therapy limited with dementia, you will probably not be able to get patient to do cognitive exercises, so SSRI's a good choice for medication, especially Celexa and Lexapro which is generic citalopram and escitalopram, Zoloft or sertraline are very safe, tried and true standard. Start with low dose, watch for side effects. Avoid tricyclics due to anticholinergic effects. Trazodone or mirtazapine or Remeron may be good choices particularly if sleep disturbances are prominent. Unfortunately, there are some studies that indicate antidepressants are not as effective in people with dementia as in the general depressed population.

Delirium is also a related condition and must be recognized and distinguished from dementia. Delirium by definition is acute disturbance of consciousness with reduced ability to focus, sustain, or shift attention as opposed dementia which would probably develop over month to years, delirium will develop over a short period of time, usually hours to days and will tend to fluctuate during the course of the day. It's often caused by direct physiological consequences of a medical condition, so if we treat the underlying medical condition hopefully delirium will get better.

Some medical conditions that can cause delirium: There are almost 8 acute illness, a memory device recorded delirium"

D-Drug use.

E-electrolyte and physiologic abnormalities

L-lack of drugs (withdrawal, like alcohol or benzodiazepines)

I-infection

R-reduced sensory input

I-intracranial problems.

U-urinary retention and fecal impaction

M-myocardial problems like MI, CHF or arrhythmia.

Almost any acute illness affects the brain or circulation to the brain and cause delirium\*

Management of delirium is just to recognize it and evaluate their medical condition. The standard test that's commonly used for delirium in the hospital is the CAM/CAM-ICU. Treat any underlying cause/general medical condition, try non-pharmacologic measures first, IV antibiotic, appropriate sleep time, you have to give antipsychotic, low dose haloperidol tried and true for hypoactive delirium, higher dose haloperidol for hyperactive delirium, Seroquel or

quetiapine the drug of choice for delirium with Lewy body disease, Parkinson disease, and less extrapyramidal side effects, always monitor QTC interval, withdraw antipsychotics as soon as possible. Benzodiazepines really only should be used for alcohol or benzodiazepine withdrawal with patient with acute delirium.

Few great recent references I would like to recommend on delirium in the internal medicine and clinical section from 2011 and very recent American Geriatric Society guidelines on delirium just published in December 2014 online, and print journal of American Geriatric Society in January 2015, just last month, the latest edition.

Very similar to delirium next we have a few slides on Behavioral and Psychological Symptoms of Dementia (BPSD) which is very trouble for both clinicians and caregivers and our focus of new government and private organizations in recent years including our sponsor, West Virginia Medical Institute, WVMI. Symptoms such as sundowning, aggression, wandering, delusions and hallucinations, prevalent up to 60-80% with dementia and frequent cause of hospitalization, institutionalization and caregiver burden/burnout. There are no easy answers in dealing with it.

You can see psychotic symptoms, hallucinations, delusions, mood/affective disorders, depression, anxiety, irritability, agitation, behavioral disinhibition or apathy, sleep disturbances which can all be very difficult to deal with for healthcare providers and family and caregivers, if you were taking care of your mother or father at home and they didn't sleep well at night, none of the usual medications for any of these symptoms are very effective in our elderly patients unfortunately. So we always encourage to try nonpharmacologic means of dealing with his first. What does that mean exactly? Most important, caregiver education, and teaching them to tolerate and accept difficult behavior, don't argue with an irrational person, just try to provide safe environment, redirect and adapted to current capabilities. When giving medications, first ask yourself are you treating the patient or are you treating the caregiver? If you judge medications are really appropriate and necessary to see the patient's psychiatrist symptoms unless they are very psychotic to the point of danger to themselves and others, you can't redirect them any other way, try avoiding antipsychotics because all antipsychotics not specifically approved for dementia patients. Really antipsychotics are approved for psychosis, that is bipolar mania and they are sometimes considered adjunct antidepressants. Unfortunately all antipsychotics have been found to carry a slightly increased risk of death in dementia patients. They have a black box warning which I will show you actually momentarily and because of this some practitioner even get written informed consent from patient or family before prescribing antipsychotics for dementia. If you do have to give antipsychotics, if you really feel appropriate and necessary make sure it's helping the patient and at least make sure it's the least possible dose for the least possible time, make sure it's not having any side effects especially in long term care facility where it's legally required to evaluate and try to reduce dose if possible periodically. Depressive symptoms is associated usually with antidepressants mainly for anxiety, irritability, agitation, aggressiveness sometimes you consider benzodiazepines like Ativan, that has limited safety and efficacy and tend to cause increased confusions and falls, so really not a great idea. Some experienced doctors will use mood stabilizers like Depakote but they have their own risk. For apathy and lack of energy sometimes stimulants like Ritalin are tried and again may have their own risk too.

Sleep Disturbance in Dementia: Very common and really hard on caregivers again, imagine a demented mother is up all night while you are trying to get some sleep before having to get up to go to work anymore, but again try to treat the patient, support the caregiver, maybe more daytime activity will make the patient more tired at night. Avoid benzos and drugs like zolpidem. Melatonin, Rozerem, Trazodone, Remeron are safer sometimes helpful. The reason why approved sleeping pills like zolpidem are bad is increased confusion and falls. Studies have recently shown that both benzodiazepines and sleeping pills are associated with increased risk of dementia and even death if you use them which is sort of concerning. Remeron is a safe drug and commonly used if the patient is also depressed and not eating well. Just discussed in Geriatric study today, a randomized placebo trial that Trazodone was detected *[Indiscernible][00:35:03]* development.

Okay, here is another polling question and based on what I said before, you probably know what my suggested answer is going to be for this case. An elderly patient, 80 year old woman with Alzheimer's is having trouble sleeping at night. She is sundowning and getting agitated and bothering her family at night who she lives with. Should you prescribe:

- A. Seroquel.
- B. Halcion or some other benzodiazepines maybe Ativan or Restoril or Xanax.
- C. Zolpidem or other drugs like Ambien
- D. Lunesta
- E. None of the above if possible.

What's your polling answer? My answer is really E. Again try to avoid any of those if at all possible, all are risky. Maybe Melatonin or Rozerem, may be nothing, which is a danger to herself other than risking her family, if she is not sleepy she doesn't have to sleep, maybe she is not tired, maybe not the customary hour but so what she doesn't have to get up, that's very easy to say and very hard to follow. Everyone including me worries about their sleep and gets very anxious and upset if disturbed and get what they feel is sufficient sleep and rest at night. Again it can drive caregivers mad, but Seroquel is antipsychotic with a black box warning. If you have a sleeping pill at night, you *[Indiscernible][00:37:03]* And all benzos cause increased confusion and fall, at least something like Lunesta is officially FDA approved for insomnia and for long term use, so if you use this at least you can't be faulted in dementia patient, I would say that's the least choice if you feel you absolutely feel sleepy, but Melatonin or Rozerem are safer. With any sleeping pill *[Indiscernible][00:37:45]* Least possible time, rare and occasional use is certainly safer than taking it regularly. Most patients get in the habit of taking this thing, and again Remeron or Trazodone can be used especially as a component of depression, officially as antidepressants.

So, here it is the actual black box warning for antipsychotics. It is basically the same for all antipsychotics, all the typical ones and all atypical ones. It says in warning, increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperdal or whichever other antipsychotic is not approved for the treatment of patients with dementia-related psychosis. That doesn't mean that it is forbidden from using Risperdal but obviously it has precautions. According to FDA, there is clinical evidence of 17 placebo controlled trials, that enrolled 5106 individuals who suffered dementia related behavioral disorder. Data from the trial

collected over a period of 10 weeks, showed 4.5% death in patients treated with Risperdal and other atypical antipsychotic drugs compared to 2.6% with patient taking a placebo. Cause of death varies, majority are cardiovascular death, heart failure or other conditions. A 4.5% risk of death compared to 2.6% risk in patients taking the placebo, that's actually a 1.9% difference. It's not really that high rate of death, it's not clear why it occurred, may be it's due to the drug or maybe it's the patient that got sicker and more likely to die anyway. *[Indiscernible][00:40:00]* And if you are over sedated or getting other side effects maybe you are more likely to get aspiration pneumonia. So I am not completely convinced myself this is serious concern to be honest but the FDA sure did. I even just heard a TV commercial the other day for a new antipsychotic, Latuda and at the end they how they quickly say all the side effects and others, etc., I noticed they specifically said Latuda may cause increased stroke and death in elderly dementia patients but they are really making a big deal.

So, here again are two great references or non pharmacological management of BPSD and avoiding antipsychotics. The left is from JAMA 2011 I believe and the right is from the other medical journal that I just found few weeks ago, a very recent issue and it said, don't use antipsychotics to treat agitation and aggression and dementia. It does say if you must use an antipsychotic give the least possible dose at the least possible time. If you have to use one, one particular articular recommended Risperdal as the best chosen one but apparently it's actually approved in Europe even if not approved in America for agitation and aggression and dementia. Here we often use Seroquel if there is a sleep problem at night involved, it's really hard and we need to educate family and caregivers on how to redirect patients without excessive or unnecessary or potentially dangerous psychiatric drugs, that's what this article is all about.

Finally, Alzheimer's can last from 4 to 10 years from time of diagnosis, if it does reach the advanced stage, patient become bedfast, unable to eat and potentially get pneumonia and malnutrition and difficult to breathe and die. It's unfortunately evitable when patient reaches this stage, with any type of palliative care, hospice care, making the patient comfortable and supporting the family. Consider referring to hospice. POST form, if patients stay in treatment which is available at the West Virginia Center for End of Life Care and should be in the nursing home or hospital.

It maybe hard to recognize if the patient is unable to tell you what's bothering them but there is the PAINAD scale, pain assessment in advanced dementia. Patient with negative facial expression will be inconsolable or strike out, we may think they are agitated and psychotic, but really they might be in pain, so maybe try a pain medicine instead of a psychiatric medicine.

Final polling question is a patient with end stage dementia stops eating and is losing weight which is unfortunately very common, without good nutrition you will die. Would you recommend putting in a feeding tube? A. Yes or B. No. Mostly people will answer no, that would be my answer. Not eating is a part of a natural dying process, putting in a feeding tube is slightly inevitable and often no help at all, contrary to popular expectations. By the time the patient stops eating that shows they are going to die soon and nothing can stop it. And a feeding tube is not to be used if it's not surgery from a complication and if it's immobilization. Patient may pull it out. And impair quality of life. If you want to be kept alive and you are saved by a tube and you are unable to enjoy eating in a normal way, I don't think I would.

So the facts are and the position of the American Geriatrics Society studies of artificial feeding in patients with advanced dementia not showing improved survival, not even improved nutritional status or functional status, even reduced aspiration or improvement in pressure sores or any other medical condition. If they are malnourished and unhealthy and alive and dying of dementia artificial feeding doesn't help. Physicians of all major organizations and expert will show you except that not eating is part of the decline process, don't try to fight it, you keep trying to hand feed, sometimes it's possible as much as they enjoy.

In my last few slides I want to show you that several organizations have recommendations like this. Part of the American Board of Internal Medicine, Choosing Wisely Campaign, each specialty of the organization has published five things not to do in order to reduce falls and improve quality of care, look what is #1 and #2 recommendations of the American Geriatrics Society. Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead, offer oral assisted feeding.

Don't use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia. Don't use them ever or don't use them as a first choice and similarly #4 Don't use benzodiazepines or other sedative-hypnotics either as first choice for insomnia, agitation. Guess what the exact same things are on the list of five things from the American Medical Directors Association and organization for long term care medicine. Don't insert percutaneous feeding tubes in patients with advanced dementia; instead offer oral feeding. These are same exact words as AGS, and similarly #4 don't prescribe antipsychotic medications for behavior and psychological symptoms of dementia, PTSD, in individuals with dementia without assessing underlying cause of behavior, again try to see what's really bothering the patient instead of trying to sedate them. and similar recommendation, actually exact same recommendation from the American Academy of Hospice and Palliative Care Medicine. Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral feeding. They are experts in many many specialties. Here is the Choosing Wisely list from American psychiatrists Association. #1 again, don't use antipsychotic medications with patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring. #3 is what the American Geriatrics Society in Canada, don't use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia and no clinician should limit the use of antipsychotic medication as pharmacological measure as the patient maybe threat to others and they know that this item also included American Geriatrics Society list of recommendations.

That's pretty much it. My last slide, here are some excellent books on Alzheimer's. If you are interested in reading, The 36-Hour day and other books.

Here is my contact information and website for West Virginia Geriatric Education Center please look up on the web, if you have any questions or comments on today's presentation.

Female Speaker: Thank you, Dr. Goldberg for this great presentation. I just want to remind everyone that if you do have a question for Dr. Goldberg, please hold it to the end in the question and answer session and we will ask you type the question in the chat box feature which is located on the right side of your WebEx player. For the second half of today's webinar we will hear

from Hannah Thurman, she is going to be speaking on the topic of national and state resources for Alzheimer's disease and related dementias. Hannah, you can begin whenever you are ready.

Hannah Thurman: Hello, my name is Hannah Thurman, I work for the West Virginia Geriatric Education Center, I am the training and development manager there. First, I would like to say a big thank you to Quality Insights, Quality innovation network partnering with them for this webinar series and we worked with them in the past and hopefully will work with them in the future, just like to say a big thanks to them, so my part of this webinar series relates to national and state resources for people with dementia and their families, I know that the folks listening to this webinar come from a variety of states and variety of settings including health agencies, physician offices, skilled nursing facilities and more and just as their variation in the way in the places where you come from there is a variation in the way services are delivered for older adults and people with disabilities, and who delivers them in different stages. So, for example you have the overall AD network structured and then you have many other for profit entities, non-profit entities, small organizations, people who are paid, people who are not paid, all of whom provide services that fill in the gap. For purposes of this webinar you are the resource, you are the person that a family member needs to turn to, you are the health professional and your goal is to help them know how to access services that are needed. You are so important for example when a family member comes to you and her mother just has been diagnosed. You can speak to her in the right direction whether you are actually providing direct services or not and navigating the long term care services and support system is difficult. I know my grandmother is diagnosed with Alzheimer's disease. There are so many different options and it could be overwhelming. So, whether you are in a state that has a no long boarding approach, I think one of us wants to go on a wild goose chase when we are trying to find the services that we need, so we are trying to get people to provide services as soon as possible with the least amount of harm.

So here are my objectives, I just talked about the importance of the first one and your role, I am also going to talk a little bit about clinical trials and tolerated to patients and families about that. Lastly I will discuss here in West Virginia we have the Alzheimer's disease registry and I want to talk a little bit about that because I think one of the nice things about this series is that we can learn from each other, we are going to have question and answer, a discussion and something is going on in one state would be helpful for someone in another state. I thought as an example tolerated about the Alzheimer's disease registry might be something that another state might be interested in.

Now let me move on to tolerated about considerations for making referrals and working with Patients and Families where Alzheimer's disease related dementia is in the picture. As far as cultural and personal preference, it might sound very obvious but it really matter to someone for example if a woman with Alzheimer's disease prefers having a woman caregiver, again it sounds simple but it could make a big difference in helping provide the care that that person wants, whom they want it from and also a cultural preference, for example that might be how moving from medical system or providing materials in the appropriate language for example are important things to consider. Also the West Virginia Geriatric Education Center, we do a lot of education around health literacy and I think some of the health literacy concepts align really well with someone who might be making a referral. The first one is limit concepts, so the idea being that most people can really only understand about 3 to 5 concepts on a conversation and

especially in making referrals, you have families that might be coming to you that might already be in a crisis. Maybe they just gotten the diagnosis, maybe the patient is in the latter stages and maybe they are all ready and overwhelmed. So if you can limit your concept in that the number of referrals and the number of resources you are giving them that will help and then also not using language that is filled with jargon, that's really important as well. Health professionals talk to each other in different ways than they would to a family member or caregiver. That type of things, so minimizing the use of jargon filled language and then teachback is another health literacy concept, makes a lot of sense when you are making referrals. So, teachback actually helps make the conversation, makes it a two way conversation, it helps you to give not only how much the person understand but how well you do in communicating what you are telling them. So all you are going to do is you ask them to tell you back what you just told them, so I think again the concept of health literacy is sort of aligned with best practices for making referrals. And then person-centered and team based care. Earlier diagnosis means some people are aware of how the disease is affecting their memory depending upon which stage they receive the diagnosis. So you would talk to someone who is an early stage much different than you would to someone who is in a later stage, and that language matters and that conversation really matters and then acknowledging and interacting with the patient with Alzheimer's disease as much as it is possible as part of the team. so it's not the provider is on the one side and practitioner is on the one side and the patient and family is on the other side, you think of it as a team, and the person or people with dementia as opposed to a demented person in terms of the language that we use. So, all those things are just considerations that I wanted to mention when you are working with patients and families.

Also I don't have it in the slide but there is a guide called Caring for a Person with Alzheimer's disease guide from the National Institute of Aging and that's a resource for more information for families that's something you can actually order more of, you can perhaps have it in your physician's office in the hospital, to get people something to take home with them.

In terms of when to refer, I think of that giving the diagnosis and the earlier the diagnosis better. Geriatricians, geriatric psychiatrists, neurologists, neuro psychologists, all of those people can diagnose but getting that going to the doctor, seeing a doctor early can help rule out and treat other health issues that might be impacting the dementia, other medications perhaps. So that's really important. Earlier the better. So also for several other reasons, one of which is it helps people plan, it helps people plan, for financial matters for legal matters, for living arrangements for example, and also helps people develop informal and formal support network to help fill in the gap. So someone who maybe even has a neighbor who helps check on them or provide a little bit of respite for caregivers you can start to develop those types of informal network and get knowledge of the different options that people have in the system, but I think it's really important that earlier the better diagnosis, it also helps people to know what to expect, know the different stages of the disease, learn as much as the disease as they can, and help get more knowledge and help down the road. And then also listed after diagnosis some of the other things, advanced directives, home safety, driving safety, all these things are really important.

What I am going to show now, I am going to talk a little bit more specifically about some national resources, I am hoping that you might learn something about a resource, that you haven't ever been told about the patient, maybe you looked at so you wouldn't have thought to tell them

about it, this site you here, the National Institute of Aging, the Alzheimer's disease Education and Referral Center, these are for health professionals, they are for people with Alzheimer's disease and their families and trying to provide current, comprehensive and unbiased education, the unbiased education piece is really important about Alzheimer's disease. So anybody can call the toll free number and talk with the reservation specialist about maybe publications that you would like to discuss, maybe a referral to a local service that they might know about and they can help with the planning team that I mentioned before, for health, legal, and financial matters. Also you can see the third tab down in the blue, they have Alzheimer's disease research centers and those physical centers can actually help in obtaining diagnosis and medical management, so that's something that a family might be interested in getting more help with, they can do that and as you can see, clinical trials, so they have information about volunteering for clinical trials, studies and patient registry, so it's just a wealth of information, maybe a caregiver wants information about bouts of disease, about maybe a clinical trial, things to read, so some really great things.

Here are some national resources I wanted to mention, Alzheimers.gov is a free resource on Alzheimer's disease and related dementias and then the Alzheimer's Association, in West Virginia Alzheimer's Association is just absolutely critical. They have news on the ground across the state and really know the communities, I think sometimes in rural areas, West Virginia is a very rural state, sometimes people they may know about the Alzheimer's Association but they may really not understand all of the different services that the entity offers, that 24 hour helpline is absolutely crucial because we all know that people experience maybe a crisis, maybe someone is wandering at all hours of the day and night, not just during business hours, so that's really really helpful, even if you just need to call get some support, to have somebody to talk to. Support groups really important as well. Now not everyone is going to attend a support group but maybe they hear about the support group early on and because they know about it, later on down the road they realized that something like that might be helpful for them, so they can attend support groups with Alzheimer's association. That tailored information is important as well, very local information about what's available and then just providing care for persons with Alzheimer's disease, just crucial.

The elder care locator is a public service of the US Administration of Aging that helps connect you to services for older adults and their families, you can search by location or by topic in your community, some other very helpful web service and you call the 800 number, you see that listed as well. Then the National Institute on Aging Information Center, if someone is interested in not just information specific to Alzheimer's disease but information in general about aging, that's a very good resource, a national resource.

I am just wondering with Alzheimer's disease some people get out of the house and the families are not able to locate them, so these two programs, they are not available in every state, I don't believe but many states have it, it depends on the local law enforcement as well but with Project Lifesaver if you have an enrolled client that goes missing, the caregiver notifies the local Project Lifesaver agency and the a trained emergency team responds to the area, so the Silver Alert Programs modeled after Amber Alert program for missing children, again signal to law enforcement an institutional alert to help locate somebody might be in danger, so these are really important to people.

The state units on aging and aging and disability is a resource for you in your state and in many states there are Aging and Disability Resources Centers. In West Virginia, the Aging and Disability Resources Network, they have a very local comprehensive web listing of available resources, long term supports and services, so in each community, as I had mentioned there are such a variety, there is a wide variety of services that's available and in West Virginia, you can look on this website and find information on anything from home modifications to mobility issues, just a huge variety of resources and services that are available through ADRN listing.

The Alzheimer's Disease Supportive Services Program just delivers supportive services, translates evidence based models and also state initiatives for coordinated systems of home and community based care. So that can be important as well. The last thing I didn't put it on the presentation but I wanted to mention. There is information out there on dementia capable communities, this information helps people learn how can we be better able to help people with dementia and their caregivers in state and community. So that's an area where some of you might be interested in listing of that information and applying it.

In terms of community-based services, I am not trying to have an exhaustive list but I did want to highlight a few helpful services, services that maybe particularly helpful when Alzheimer's disease related dementia is in the picture. Home health and nursing home compare those are websites that help families search by facilities and you can look at information about for example patient safety in a certain facility, so that can be helpful. Senior centers, in some states the Agency on Aging provides home delivered meals, congregate meals, again very important service. Dementia/Memory Units, when wandering is an issue, these units are helpful, that's a huge relief. Adult Day Care, if you are lucky enough to have daycare in your community, that's really helpful, respite services and if a person with Alzheimer's disease is in a long-term care facility, the state's long term care ombudsman covers that area is really there for you to help stand up for the rights of the person in the facility. Another resource, another advocate in your community for a person with Alzheimer's disease, related digital marketing, who is living in a long term care facility.

Again, the PACE programs, we don't have this in West Virginia but other areas have these programs, the programs are all care for the elderly allow eligibles, often does with multiple chronic conditions, continuing at home instead of moving to a long term care facility.

Also want to talk a little bit of time to highlight some state program that I ran across when I was researching for this presentation. The Delaware Alzheimer's Association has a Julie H.C. Bailey Learning Academy and they focus on doing consumer education program in their 18 county service area. Delaware also has a plan to address Alzheimer's disease and related dementias as do some other states, those plans specifically align with the national plan, so you can look for those plans and what states might be doing to address the goals of the plans.

In Louisiana I found the Charlie's Place Respite Center, this is a center that provides a non threatening home like experience where participants participate in like therapy, gardening, they even have a culinary school, so really tailored activity for patients with dementia, and then the resource center in New Jersey, they have a young lives group, and it's specifically for woman

who partner for developed dementia in their 30, 40, 50, very unique program I think and I have to mention the geriatric education center, the three I have listed, GEC of Greater Philadelphia, Eastern Pennsylvania, Delaware GEC and GEC of Pennsylvania, these have focused programs on dementia where geriatric mental health and helping not just health professionals, training health professionals but helping patients.

And then West Virginia we have the Center for End of Life Care a great website, a great resource that helps all West Virginians and pain control at end of life. They have a registry that people can submit there with advanced directives and people with disabilities can go and look at those advanced directives.

Family In-Home Respite or FAIR Program is a program from senior services, state unit on aging that's administered out of the county aging program which provides respite for caregivers who really need that break and the person from senior center goes and does activities with persons of Alzheimer's like to do, so garden intelligent, cooking, different things like that, and interestingly in West Virginia some of the funding for the program comes from cable games from the state, sort of creative funding mechanism for that program.

And then the Alzheimer's disease registry, I want to show screenshot of the registry. This is a popular conveyed disease registry that helps show the need for accurate and timely assessment of the incident and prevalence of Alzheimer's disease in West Virginia, it collects information on Alzheimer's disease and acts as a central database and helpful for policy, planning, research concerning Alzheimer's disease in our state, so physicians are start to registry to obtain access, there is a secure server, this is something that not every state has that other states might be interested in having.

Clinical Trials: The Alzheimer's Disease Education and Referral Center and Alzheimer's Association TrialMatch those are resources that actually have individuals that help watch people through the process of participating, I think that's really crucial because sometimes participating in clinical trials can be daunting or intimidating, so that's really helpful, that you can talk with someone who can help you find the appropriate trial. Helping people who need, not just people with Alzheimer's disease and I saw a study that from 2014 at least 70000 volunteers are needed to participate and than more than 150 active clinical trials. So it's an opportunity for people to find out about possible treatment, but also to feel like they are doing something for the next generation, we feel like they are making a contribution.

This brochure is another piece of publication that you want to give people more information about participating in Alzheimer's research, this is a really good brochure from the National Institute of Aging, again you can order this publication either PDF, available for free, but publication you just go to the website and order, I also want to mention that many of the resources on the National Institute of Aging site you can access on your Kindle, so having information in many format is important when you are looking for patient assistance.

So in conclusion, your role as a health professional is crucial, you help people know about this, you help people feel less overwhelmed, help get them the services that they need as soon as possible and you are a trustworthy person that can help them, so you are really really important,

you help them access resources early which is critical and you want to consider talking to patients and families about clinical trials. That's all I have for my part of my webinar, thanks so much.

Female Speaker: All right, thank you so much Hannah for another great presentation, we got such valuable information today and right now we are going to go ahead and begin the Q&A portion, of the webinar and again I would like to remind you that you have a question for Dr. Goldberg or Ms. Thurman please type chat box feature which is located on the right side of your WebEx player. So looking at some of the questions we have, looks like the question is for Hannah, Hannah, are you there can you hear me?

Hannah Thurman: I can hear you, can you hear me?

Female Speaker: Yeah, great. so this is question from Carolyn, she asks why is it important to refer patients and families to someone who can provide a potential diagnosed of Alzheimer's disease or related dementia early?

Hannah Thurman: That's a really great question I think you said Carolyn, so I mentioned during the presentation there are really several reasons why it's important to get the diagnosed as early as possible and some of those would include helping people plan, helping people make different living arrangements, helping people determine financial and legal matters so really getting a plan in place would be part of the reason why it's important, also for example if someone doesn't have a lot of informal support network available to them, it would give the family time to put some of those in place. I think I mentioned in the presentation an example of a neighbor that could maybe check in every once in a while, so helping develop support network, that will be another part of it, also linking caregivers to support groups, that will be another piece, and then I think sometimes as health professionals we forget how interested families are in learning about the disease itself and if you get the diagnosis early you can learn as much as possible about different stages, so you know what to expect, what's coming down the road, and how the disease impacts the brain, so I think that's not exhaustive list but it's a few reasons I think why it's important to get that diagnosis early.

Female Speaker: Okay, thank you so much, it looks like we have another question for Dr. Goldberg, Dr. Goldberg are you on the online?

Dr. Todd Goldberg: Yes, I am.

[Off the record conversation]

Female Speaker: This question comes from looks like Mardo, is there any awareness of the use of Nuedexta in the treatment of episodic behaviors or BPSD, anxiety, etc, associated with dementia?

Dr. Todd Goldberg: That's a very good question, I was just asking a geriatric psychiatrist the other day that I was at a meeting with , I just returned from the American Medical Doctors Association meeting in Louisville, Kentucky and went to a lecture about dementia and that was

one of the drugs that was mentioned, so Nuedexta, the question asked about is a fairly newly drug that's a combination of two old ingredients, called Quinidine and dextromethorphan which is also in cough medicine and for some reason this combination has effectiveness and has been approved not for dementia but for what's called pseudobulbar affect also known as pathological laughing and crying, also known as involuntary emotional expressive disorder, IEED, that's what you may see in the commercials. So people with certain neurologic disease including Alzheimer's sometimes tend to inappropriately laugh or cry at the slightest provocation and that's really what this drug is approved for. I have not seen it used for agitation or anxiety and dementia in general but I have tried it a few times on patients who seem to have inappropriate emotional responses, it is a new and fairly expensive drug, it doesn't seem to have any danger, so it's okay to try, if you think the patient is suitable.

Female Speaker: Okay, thank you very much, we have another question from Karen and it looks like it could go to either one of your Dr. Goldberg or Hannah. The question is I have heard concerns about families not wanting to disclose the Alzheimer's or dementia due to patients being labeled and having difficulty being able to get resources, for example, insurance, could either one of you speak for that.

Dr. Todd Goldberg: Sure I could. That's another interesting question is should you label people, maybe that's one of the reasons you don't want to give early diagnosis is that you don't want people to be labeled when they are really not that impaired yet because that might affect them at work or insurance, you want to be honest with people and they need to know what they have. So there is a controversy about telling people that they have Alzheimer's and it was even in the news just this week, I can't remember where the story came from, I just saw it yesterday that many people with Alzheimer's have never been specifically told that they have Alzheimer's by their healthcare practitioners which doesn't seem right. There is potentially a problem yes with labeling people and they might have trouble getting insurance or jobs if they are not impaired yet. Now, with health insurance under ObamaCare you are not supposed to be insurance based on preexisting conditions and everyone has to have health insurance now, so that shouldn't be a problem, but life insurance or disability insurance it could definitely be a problem. Another interesting aspect is I wanted to mention also information that I came back from the American Medical Directors Association is that people are being labeled with Alzheimer's earlier and earlier even before they have dementia I actually wanted to correct the statement that I made last week that Alzheimer's is a type of dementia because if you have very very early Alzheimer's and the plaques and tangles developing in your brain, you might not be demented yet, at all but you still sort of have that disease building up in your brain just like you have cancer or heart disease and not know it yet. If you are a perfectly cognitively normal person but they were able to detect by some blood or genetic test that you have incipient Alzheimer's disease would you want to know that? You would be frightened, somebody wouldn't want to give you life insurance or health insurance or let you open up a bank account. It could conceivably have serious impacts, so the speaker Dr. Jason Carlo is from the University of Pennsylvania and you learn article about this in Health Affairs magazine last year that society is going to have to deal with these problems as people are diagnosed earlier and earlier, that was really interesting to think about.

Hannah Thurman: This is Hannah, I just wanted to mention that Dr. Goldberg probably where you saw that figure the 2015 Alzheimer's disease facts and figures came out very recently and

they say that only 45% of people with Alzheimer's disease or their caregivers report being told of their diagnosis.

Dr. Todd Goldberg: That's probably the figure I heard.

Hannah Thurman: Yeah, it's really interesting, yeah, the different ethical issues involved with that as well, it's a great question.

Dr. Todd Goldberg: In the past we used to be afraid to tell people they had cancer because they would be upset, they would think they are going to die and now you have the same issues, in a way a stigma to tell someone they have Alzheimer's but as healthcare professionals we have the obligation to be honest, patients have autonomy and rights and again people need to know their situation so they can be prepared.

Hannah Thurman: Absolutely, that's exactly the comparison that they make in that report, they saw that more than 90% of people with the four most common types of cancer have been told of their diagnosis. So, they are sort of comparing it, so that's interesting.

Female Speaker: Okay, thank you both very much. The next question we have is from Catherine. Catherine asks how do you suggest one addresses the ethical issue involved in complying with moderate to severe dementia patient who insisted on a feeding tube instead of hospice as she wanted to live, this is a real scenarios from my mother in law and my family who brought her home with a tube from the hospital and cared for her for one full year with feedings at night, she had a durable power of attorney, expressed her desire early not to be a prolonged with a terminal illness, yet she was intermittently clear in that she stated that she wanted the tube.

Dr. Todd Goldberg: That's a really tough ethical issue. Because people make advanced directive that say one thing but they have the right to change their mind but I moderate to severe Alzheimer's usually you really don't have decision making capacity to make a serious medical decision and that's one of the things that Dr. Carlo also talked about in his lecture in his article in health affairs. So listening to that patient when they made a serious decision that contracted what they said before, it was really an ethical dilemma but if someone said they wanted it it's hard to say no or refuse to do it and lot of doctors have discomfort with this issue too and lot of families, so we tell people don't get PEG tubes but if they insist on it and they want it it's hard to say no. It might have been a case even for an ethics committee to look at the basis for the decision

Hannah Thurman: You talked about more in terms severe dementia how feeding tubes just really aren't appropriate but it's difficult to talk to families about that certainly, and we try to talk them out of it but if they really are convinced that they wanted it and it helps, it would be very hard to refuse for a doctor to say, absolutely not, I feel that's inappropriate and ineffective, you would have to have a lot of guts to do that, some people might but I wonder in this case, why she needed it. Of course we don't know the details, does she have moderate to severe dementia, if it's moderate they are usually still able to eat, if it was severe dementia then it would fit in a case we are talking about and if she died anyway after a year, that's sad and that's exactly why we don't

usually recommend them because they don't really work, it's hard to adhere to these rules a 100% of the time and emotionally and philosophically in a murky situation.

Female Speaker: All right, thank you so much, looks like we have time for one more question. The next question comes from Carolyn and she asks, why is it important to refer patients and families to someone who can provide a potential diagnosis of Alzheimer's disease or related dementia early.

Dr. Todd Goldberg: I think Hannah already answered the exact same question at the beginning,

Hannah Thurman: Yeah, I think so.

Dr. Todd Goldberg: I think so.

Female Speaker: Yes, you are right, one more then, Josh asks, what are some resources for locating clinical trials?

Hannah Thurman: I can take that, one would be [clinicaltrials.gov](http://clinicaltrials.gov) So that's one resource and then I think the two other ones I want to mention are particularly important because the Alzheimer's Association TrialMatch and the Alzheimer's disease Education and Referral Centers, both of those entities actually have specialists that can walk you through the process of participating in clinical trials, not just people with dementia but healthy people as well, volunteers who are healthy, so they can walk you through the process of finding the appropriate trial, things like that. I think those are three resources right here for locating clinical trials.

Dr. Todd Goldberg: Definitely, Josh, looking at it now, just type TrialMatch into Google and it will take you right into the Alzheimer's Association website on that.

Female Speaker: All right, thank you both very much. Unfortunately that's all we have time for today. if you do have some questions for Dr. Goldberg or for Hannah, please continue to type it in the chat box, and I will see about getting those answered for you after the webinar concludes today. We want to sincerely thank each of you for joining this presentation and learning more about Alzheimer's disease and related dementia and again there is one remaining webinar in the series and I would like you to encourage to register for that, if you haven't already done so. You will receive an initiation to register for this after the webinar concludes today. Finally, I want to ask you to take a moment to complete the evaluation that will pop up for you when you exit this webinar, we want you to know that your input is very valuable to us. Please continue to visit us online [www.qualityisgihts-qin.org](http://www.qualityisgihts-qin.org) to learn more about the things we have going here at Quality Insights, or you can contact any of our experts at anytime by accessing their contact information on the website. Again, thank you so much for your participation and have a great afternoon.