00:05.22

Matt Brandenburg

All right today we are joined by Stacy Smallfield and Liz Metzger I want to thank you both so much for sharing your knowledge and expertise on the show with us today.

00:15.91

Liz Metzger

Happy to be here.

00:19.73

Stacy Smallfield

you're welcome.

00:22.41

Matt Brandenburg

You two co-authored the occupational therapy practice guidelines for adults living with Alzheimer’s disease and related neurocognitive disorders. Can you quickly define for us. What a practice Guideline is and how this publication can be used by students and practitioners. And educators.

00:42.20

Liz Metzger

I'm sure well to start I just want to point out that while we're the 2 coauthors listed on the practice guidelines. There were 3 other occupational therapists that were a part of the process and worked on creating much of the guidelines as well, but essentially the practice guidelines are a part of Aota's practice guideline program which relies on the integration of information from clinical expertise preferences from clients and finding the best available research the practice guidelines provide information and guidance on the best available research. And they rate how confident a practitioner should feel about a recommendation so we only do strong or moderate recommendations. We don't provide weak recommendations based on the quality and significance of the studies for this practice guideline we only included meta-analyses. So again, we used the highest level of research for this project and for the purpose of students practitioners and educators. We hope that it's a. Easy way to synthesize the information that's available out there I like to say we read all the research so you don't have to that doesn't mean that you shouldn't continue to dive into the studies because again this is a very big overview umbrella of stuff. So for the more detailed minutiae of how to actually execute some of the recommendations I would still recommend going to the literature. We also ah hopefully provide useful information to researchers about the gaps in the evidence and we're 5 years from now when this project is done again. Ah, that hopefully they'll be they can fill in those gaps and that can improve the evidence to support occupational therapy interventions.

02:31.24

Matt Brandenburg

I love that I love that, and I love our interviews about practice guidelines. for one because it usually means I get to speak with recurring guest Stacy Smallfield because you've been a part of so many practice guideline publications, but also it's such an important document and resource, so thank you both for your work and for the whole team's work on this practice guideline. What would you say kind of motivated each of you to focus your efforts and scholarship on Alzheimer’s disease and related neurocognitive disorders.

03:09.20

Stacy Smallfield

Yeah, I can go first on that one. My clinical practice is with older adults before I transition to academia. So certainly, a population that is near and dear to my heart if you're working with adults or older adults in practice you are going to encounter someone Who is experiencing Alzheimer’s disease or related Neuro Cognitivenitive disorder or mild cognitive Impairment. So , we need to know about how you know which interventions are most effective. for this population and then in general. Ah, have an interest in chronic conditions and really prevention of chronic conditions through healthy habits and routines and so of course Alzheimer’s disease and related dementias happen probably in part because. Because of Lifestyle factors or other things potentially along the way and so I think OTs also have a role in figuring out how we can best support preventive efforts before we get to Dementia or the dementia phase, so that's where my interest lies.

04:30.33

Matt Brandenburg

I love that and how about you Liz?

04:32.18

Liz Metzger

Yeah, so I am a practicing clinician and I have always worked in geriatrics I've wanted to be a geriatric occupational therapist since I was 11 , so I've always known that I was going to work with individuals with cognitive impairment and I've seen those individuals, across many different settings. I've also been on the board of the allen cognitive network which promotes the use of the cognitive disabilities model since 2011 so I'm really passionate about identifying interventions that can best support individuals and care partners that are dealing and living with dementia on a personal level I have many family members that have been affected by dementia and have definitely received less than best practice care. So. Providing more information to clinicians on best practice here is really valuable and really important. So, I come to it as a clinician that wants to make sure I'm doing what's best but also want to make sure other clinicians are supporting. Ah, their patients as well and demonstrating the importance of occupational therapy in this setting with this population.

05:42.95

Matt Brandenburg

Absolutely well the time and effort that that you both put into your care your practice and creating evidence and resources for other practitioners and professionals is truly appreciated. I had a Little bit of a follow-up question I Know the title of the guidelines mentions adults living with Alzheimer’s disease and related neurocognitive disorders, how interchangeable are neurocognitive Disorders Alzheimer’s and dementia in terms of Terminology. , why is there kind of that distinction in the language and what's ah the importance of really using the correct terms when talking about this population and this publication.

06:29.41

Liz Metzger

That's a great question. It actually took us a little bit of time to finally land on Alzheimer’s disease and related neurocognitive disorders, and the past I've used ad Rd so Alzheimer’s disease and related dementias, however, this is more specific again. Dementia is an umbrella term. It's not a diagnosis and when you look at the research a lot of it is specifically on people with Alzheimer’s disease which is a unique disease process and it accounts for 60 to 80% of all people with a type of dementia. But what we also found in the research was information on mild cognitive impairment which is not the same as dementia. There will be people with mild cognitive impairment that will progress into a stage of dementia or into Alzheimer’s disease. Ah but not all of them and so we wanted to clarify that also for future practice guidelines or just for. Ah, people's awareness. There are other forms of dementia that we may be seeing Parkinson's is one of them and there's a host of other ones as well that we wanted to be inclusive of in our evidence search even though our research typically either specified ah like Alzheimer’s disease. Mild cognitive impairment, and in some cases but not many it was dementia but not specify the type of dementia so we wanted to be inclusive of all of those.

07:52.27

Matt Brandenburg

Thank you that really clears things up for me. I practice in an outpatient pediatric setting. and you know so aren't working with patients who have you know Dementia Alzheimer’s disease and a lot of these related neurocognitive disorders, could you both kind of give us an idea of what the functional implications of Alzheimer’s disease and related neurocognitive disorders may be.

08:22.79

Stacy Smallfield

Sure I can start with that. You know it starts with changes in memory planning decision making and in general cognitive decline and so functionally that means people may have. Challenges participating in work If there's if they're working or volunteer activities maybe difficulties managing their household maybe finances Health management activities may decline because of that cognitive. Those cognitive limitations. , then as and the condition Worsens It's a progressive decline in cognitive Functioning. So then they may a person with Alzheimer’s Disease or a related neurocognitive disorder. May become more disoriented have confusion experience some extreme mood swings or sensory changes and so this of course then leads to things like irritability wandering Restlessness anxiety depression. Which all play into someone's ability to have healthy social relationships again just ability to go through the day completing all of those you know work leisure home management types of activities. Sleep also plays into this. They may eventually experience some sleep disturbances and so then that rolls into performance of daytime occupations. So really, ah, can lead to an overall occupational performance deficits in lots of areas.

10:16.36

Matt Brandenburg

And absolutely I think anytime someone's experiencing cognitive limitations and decline really every action that you know requires conscious thought is really impacted, if someone's really, you know, ah Experiencing these functional Limitations. So globally, how would you kind of describe the OT process does it does it change or are there different approaches that a clinician should use when working with adults who have these disorders.

10:49.38

Liz Metzger

I Think the process is similar but what might be different than some of the other adults diagnoses is the importance of the caregiver or the care partner as we call them in the practice guidelines. , because. So much of what's going to happen during the progression of the disease is going to require compensation versus remediation and that's going to have to be provided by something outside of the individual so and in the environment which obviously includes the care partner and again. Each process is so unique because each individual is their own person. So Someone may be in the stage same stage of Dementia but the way that their symptoms manifest may be different based upon their prior level of education their temperament. Ah their preferences. And with that in mind the Clinician really has to do a good job of building an occupational profile and not just identifying the needs of the individual but the care partner who could be a formal care partner or paid care partner or maybe a family member or loved one as well.

11:53.73

Matt Brandenburg

Absolutely.

11:53.89

Stacy Smallfield

Yeah I Definitely agree with that I will add on I think we've been asked several times why the term care partner rather than caregiver and that that is a word we were using intentionally to describe the. Transactional relationship between the people. It's not just a caregiver it kind of has a connotation of a 1 ne-way relationship where care partner both parties or multiple parties are involved in that relationship and so that's why we're intentional. About using the term care partner.

12:35.55

Matt Brandenburg

And ah, thank you for that. Ah clarification that makes a lot of sense and especially coming through an OT lens we want to treat people and that includes working with care partners and making sure that their needs and well-being is also Considered. , so that's very important. , what would you say are some typical issues associated with functional cognition. , you mentioned you know a couple symptoms and ways that these disorders may , express themselves when clients. Ah but what about?? . Things related to altered perception thoughts mood and behaviors that adults with Alzheimer’s disease or related neurocognitive Disorders may experience.

13:25.57

Liz Metzger

I Think that that's like such a big question right? that that's sort of summarizes What we're dealing with where you need to look at all of these pieces and how they are impacting the person's performance so inevitably this is going to impact their relationships. And it's going to impact their functional performance. So if somebody has a decline in their ADL function. It could be because they are uncomfortable in the shower space. Their perception of the space is different. It could be volition. It could relate to depression and not being motivated So there's just so many pieces. That could be impacting function and it can be really challenging to tease all of that out when you're building your occupational profile and when you're looking at all of these performance patterns and it's it can be a very overwhelming experience especially for New Clinicians or when you're looking at integrating best practice. But I think the big piece of this is really identifying what the individual cares about because unless they care about the intervention that you're trying to Execute. It's not going to happen.

14:33.90

Matt Brandenburg

I Love that I Love that ah recommendation of focus on what the person really cares about and I can definitely relate to that feeling of being overwhelmed, especially when we're working with a client who has a condition like this that can. Affect them so personally and so globally and in so many different ways, how would you recommend practitioners approach using the practice guidelines publication kind of how is it organized and how should they use it to kind of help with that overwhelming sensation that so many practitioners Do feel.

15:12.94

Stacy Smallfield

Yeah, so , the practice guideline is organized into a few you could kind of chunk it into about 5 or so parts first part of course is a general introduction background to. Alzheimer’s disease and related neurocognitive disorders. But also ah our introduction to the practice guideline what it is what it's used for that kind of thing then it progresses to the clinical recommendations. That came out of the systematic review briefs that informed the practice Guidelines so whenever a practice guideline is developed. It is based on. Of course the most up-to-date research evidence. We did those the. Systematic reviews in the evidence and that resulted in 4 systematic review briefs that are published in AJOT already. But those inform those clinical recommendations the next section the third section then after. Recommendations that are based on current evidence then we go to expert opinion which we do expert opinions for important or common clinical interventions that we may see in practice that didn't reach the level of an evidence-based clinical recommendation. Due to the amount of research that that particular intervention has so there are a few of those in the practice Guideline and then we move to case illustrations so we have 2 case examples of cases that might come up in practice. Ah, how the clinician in that case can use the evidence to guide their intervention planning and so with there's specific assessments that are used. You know it takes you through the OT process with two cases. Everything from the occupational profile. Assessments intervention planning intervention sessions. How those might be how our clinician could code or bill for those sessions and then the outcome of that So we do that with 2 different cases and then we end the practice Guideline. With some knowledge gaps. So We talk about things that maybe we're not seeing much in the literature yet that we may want to be paying more attention to. So That's how the practice Guideline essentially is organized and you know if you're looking for if a practitioner or a clinician student is looking for a particular Section. You certainly could j p to the part that you would find most useful are the things that you're particularly looking for. And don't know that a person would have to read it from front to back to find value in it.

18:16.89

Matt Brandenburg

Absolutely I love practice guidelines I still remember the first time I read one as a student and I felt like I was cheating because there's so much knowledge and it's organized so well and now as a clinician. It's everything that I would need that Can really answer a lot of my questions is all in 1 resource in 1 place. , so it's so helpful.

18:33.31

Stacy Smallfield

I will say that sorry to interrupt I will say that practice guidelines have evolved over time. They do look a little different than probably the first one you read. And in a good way. They've transitioned to be even more user friendly to the clinician they are not repeating as much information from the systematic reviews as perhaps they once did but rather are translating those systematic reviews into. What can how can I use this? what does this look like in my practice and so you'll see the case is much more time spent on case examples much more we have evigraphs in this practice guideline that really are like 1-page cheat sheets that ah. Clinician can keep on their clipboard or hanging on their bulletin board at work to refer to easily so there are more and more knowledge translation pieces in practice guidelines than there were previously.

19:42.68

Matt Brandenburg

I Love that knowledge translation. I Just I love that. I Love the way you describe that and it's really evident in these guidelines. How it supports knowledge translation for the user and for the clinician, let's go ahead and dive into some of the results of the practice guidelines starting with those systematic reviews. that you mentioned what? what are some of the clinical recommendations or interventions that are most strongly supported by evidence that came from those systematic reviews.

20:13.53

Liz Metzger

So One of the most exciting ones again for me as someone that's had this actually sort of started to change the way I think about my own interventions is cognitive improvement. Which is not something one associates with Dementia The assumption has always been that we can't fix cognition but what we actually found that there are strong evidence to support cognitive-oriented approaches for improving cognitive functioning. , so that's really exciting because that means OT interventions that focus on improving cognitive function should be considered on the table. There's also strong evidence that exercise can improve cognitive functioning, as well as music interventions especially when paired with movement as well as reminiscence intervention. So All of those are useful for cognitive improvement. and just to sort of Clarify. We organized our articles By. Outcomes versus interventions so depending on if I were a clinician looking at this. My first thought would be if I would like to address this deficit. What intervention should I do and so the first one is that we identified was cognitive improvement, there was also moderate support for dance specifically for people with mild cognitive impairment as well as cognitive oriented approaches for people with mild cognitive impairment. , the second area we looked at was depression and there was strong support for reminiscence therapy for dementia. As well as moderate support for non pharmacological interventions. for reducing symptoms of ah of depression for people without a diagnosed major depressive disorder, there was also moderate. Support for addressing depression using music and then physical exercise and ah cognitive interventions for a mild cognitive impairment as well as one on one treatment for cbt for anxiety and dementia, so what we're seeing also is that there's. Certain interventions that have positive impacts on multiple areas. So Reminiscence is good for depression and cognition and physical exercise is good for both as well and these are helpful for therapists to consider like what's going to be the best use of your time. How can you hit on the most problematic areas or areas that need intervention at the same time. Ah, for pain There was moderate evidence for individualized sensory stimulation to reduce observed pain in people with dementia, and our final area was caregiver interventions in general.

23:04.38

Liz Metzger

And there was strong evidence for multicomponent education interventions which could include peer or psychological support to address care partners with Dementia and then there was moderate evidence ah for education and skills training and case management to reduce. Behavioral and psychological symptoms in individuals with Dementia as well as their care partner reactions as well as moderate evidence for behavioral activation interventions in the home setting to reduce depression and so I just spit out like a ton of words and I realize that now so I'd say the most useful. For me the most useful way to process this information would be to go and look at the Evy graph to sort of see how we broke it down there. But if you're an auditorial learner. Maybe that made complete sense to you.

23:49.75

Matt Brandenburg

Hopefully and hopefully you're listening to this episode with the practice guidelines you know, open on your screen or at a physical copy so you can do that multimodal learning with auditory and you know physically as well. .

24:02.75

Liz Metzger

Which the research supports, right.

24:06.95

Matt Brandenburg

Ah, yes, yes, we are everything supported by research on the show. As you mentioned based on the review, practitioners should consider using all these different approaches to address pain behavioral and psychological symptoms cognition and care partner support, I'd like to go a little more in depth for each of those and ask you to share some clinical recommendations, there are considerations that practitioners should keep in mind when deciding what intervention to use and how to implement it and determining whether it's appropriate for their clients or not, so let's start with mental health outcomes for Caregivers. What are some clinical recommendations that you would give to practitioners about interventions specifically designed to address mental health outcomes for caregivers.

24:57.37

Stacy Smallfield

Yeah I would say my first suggestion would be using cognitive behavioral strategies or mindfulness interventions for care partners to support to do reduce depression For the care partners. My second thing and I believe Lud's already touched on this was ah multicomponent education so or psychological support interventions so making sure that. Number one that they have their own tools and strategies for reducing depression or reducing stress and then that we're also providing them with the education. They need to be effective care partners. So those are probably my top 2 things that I would go to. To use in supportive care partners.

25:53.33

Liz Metzger

And from a timeframe perspective most of these interventions took place over a 6 to twenty week period so when thinking about again dosage is such a thing that we don't talk enough about and don't research enough and as a result. Feel like it's impacted our ability to administer sufficient therapy services. So like in home health where I am for example, right now. Typically I can't get more than four or five weeks with a patient and knowing that interventions that address this typically should last longer than that time period pushes me to request more time from agencies to make sure that I have sufficient time to execute some of these interventions.

26:36.67

Matt Brandenburg

Absolutely And that's an important advocacy piece, what would you recommend to practitioners who are kind of facing that same dilemma where they'd need more time. How should they approach requesting more time and more dosage to be able to provide these interventions in the best possible way?

27:00.20

Liz Metzger

I think it's 1 building relationships. So I have pretty good relationships with many of the agencies that I contract with so when I call Samantha at agency I I know that she knows that I know what I'm doing and I'm not trying to milk them for visits. I can also reference that hey I just read the recent practice guideline and the dosage recommendation for this intervention is this and I think it's going to have a positive implication on our oasis and again like being able to reference the things that the agency cares about which is that our ending oasis. Looks good and demonstrates progress, also noting that if we can get this caregiver really situated in this education and make sure that they're enforcing all of these strategies. We have a decreased risk of rehospitalization which is also a big negative for these aid for home health at least that is a really big deal, so again, ah, you need to think about not just the interests of your patients but the interests of your payers.

28:00.93

Matt Brandenburg

And that's such a good point too. And another reason this practice Guideline is such a valuable resource having this information and evidence and instruction on how to apply it can really help practitioners increase their scope and begin to advocate for more care, that's needed for their clients and increase you know the impact that they're having and the overall well-being of clients and so thank you for sharing that? you mentioned earlier Liz ah, some of the evidence supporting reminiscence therapy. what? additional clinical recommendations would you both give. About interventions that address behavioral and psychological symptoms and specifically how reminiscence therapy could be used.

28:46.40

Liz Metzger

So. What's really frustrating about a meta analysis is that it is a giant overview and they don't go into a ton of detail about the actual interventions, and there was a conscious choice made not to deep dive into the specific RCTs that were mentioned in the articles because that would turn into a giant ball of spinning bigger. But basically the way that I see reminiscence being used, especially for the sake of behavioral and psychological symptoms of dementia; again is especially with caregivers to help individuals that are having a moment of crisis or struggle to ground them in something that they that is meaningful to them So We know that for people with Dementia long term memory is one of the last things to go so it can be really comforting to be grounded in something that's happened in your past. So For example, when I was working on a sub acute rehab community we'd ask family members to bring in pictures so that if their loved one was having a moment of crisis we could look at pictures from the past that could sort of reorient them to who they were and that can provide a lot of calm for the individual Also for care partners, especially informal care partners that have that are in the process of.

30:08.59

Liz Metzger

Losing the person that they care about connecting through reminiscence is an opportunity to make sure that they still feel connected to who that loved person. Loved one was even if their person doesn't exist as they currently are so I'd say anything from music so familiar musi.c I Know people really enjoy that pictures from the past just talking about past events can be really beneficial for making people feel more calm in the moment and also more present so they're less focused on the anxiety or the sense over sensory stimulation that might be happening and can focus more on who they are and what they're about.

30:45.90

Stacy Smallfield

I would say also, just related to the literature on reminiscence therapy, most of the studies that have been done are more group based than individual but there is there i research that supports reminiscence therapy either as 1 on 1 or in group sessions and the dosage is up to 12 sessions is where the current literature is on that.

31:17.30

Matt Brandenburg

Thank you thank you it sounds like ah, a powerful and really a beautiful intervention too that that brings a lot of meaning and has kind of that that grounding effect like ah Liz mentioned and Stacy you mentioned Mindfulness earlier. Does that kind of tie in with reminiscence therapy and is it kind of using mindfulness and reminiscence at the same time to make sure ah that the invent the intervention is , really ah effective.

31:47.94

Stacy Smallfield

I would say mindfulness applies probably more to care partner training in this regard rather than to the person with dementia so, would lean toward no on that. But I will say that there is a lot of literature in terms of addressing depressive symptoms and behavioral symptoms of dementia. There's literature that promotes some of these non-drug interventions like OT cognitive stimulation and plus exercise plus social interaction, touch, even massage and touch, that these things are more effective than a drug intervention for addressing depressive symptoms. So that is something that I think is really important to keep in mind we have ah OT can play a really critical role on the Healthcare team. By doing some of these interventions rather than turning to necessarily to drug alternatives.

33:05.67

Matt Brandenburg

I Love that That's ah, that's really impactful. That's such an important piece of information and evidence to keep in mind when approaching working with this population, you both have mentioned some interventions that are supported By. Ah, the literature and evidence to address cognitive decline in cognitive function, can you share some clinical recommendations for how to use music, exercise or dance, and other cognitive therapies to address cognition.

33:38.79

Liz Metzger

Well, what we know is that both group and individual cognitive interventions can be effective and those can happen from 2 to 6 times a week normally for about 30 minutes is the average for sessions, so that can include also using a cognitive oriented approach. But again what we found is a lot of interventions used multimodal interventions so they didn't just do 1 thing. It was OT and music OT and cognitive oriented approaches. So ah. I'd say that leaning more towards throwing the kitchen sink at things is not necessarily a bad idea. Obviously you don't want to overstimulate someone or try too many things at once but based upon the individual's profile and what seems to be they're responding to It's. Very useful to do multiple interventions at the same time. So like music combined with movement. Those are 2 intervention strategies that go really well together. , but as always clinicians who sort of look at the implications and what's actually happening with their intervention and. Coordinate and collaborate with other providers to make sure that it's having a positive effect and that potentially other care providers are curing out components of these interventions as well.

34:50.92

Stacy Smallfield

Yeah, and I'll add to that and saying this is this is where the expertise of OT comes into play. We know things like music and exercise are very beneficial. So how can we build it into someone's daily routine so that it's. Becomes a habit right? 30 minutes of walking or any kind of group exercise session every day whether that's someone that's living at home or whether they're living in maybe skilled nursing or something like that. How can we build in music every day. How can how what's the time of the day that that's in their schedule so that we're creating just ah, ah reducing potentially the likelihood of depressive symptoms or things like that to occur. So. Think of all from an OT perspective I'm thinking about if I'm working in a care facility. How can I work with my team to do a routine restorative exercise program. How can I work with activities to do a music. Type of intervention. Routinely how can you know so building things into just daily habit is where I think the OTs can really shine.

36:22.25

Liz Metzger

And for people with Dementia routine is really important having predictor full schedule is really valuable so it's ah it's a win on both on multiple fronts.

36:31.12

Matt Brandenburg

Absolutely and you do are touching on such ah relatable and important points. , you know I go back to what I said earlier when as a student I. Got this practice Guideline and I thought Wow this has like all the answers to what I'm learning right now and what I need to be learning. , but as is mentioned in this practice Guideline You know in the real world. Once you're a clinician and working with people very rarely will practitioners find an evidence-based intervention. That perfectly fits their clinical setting and the clients specific needs, so these considerations are so important to keep in mind what other advice or recommendations would you give to clinicians in regard to their clinical reasoning considerations. Why they're consulting practice guidelines.

37:26.53

Stacy Smallfield

Yeah I would always start with is it a match right? is what's being described in the practice guideline how close is does that match the setting that the clinician is currently working in, if it is a match. Great. Go ahead if it's not to match I would first want to consider are there interventions that are a match a close match with the population I'm working with in the setting I'm working with and those kinds of things if there's not a match then. We would need to keep in mind can I still use it or how might I adapt it? and use that Intervention. You know if we decide to go that route my recommendation then is can they collect evidence is it is the way they've modified it. For their setting or circ stance as effective and we don't know that unless we're collecting some data about that. So is there some outcome data that can be collected to know if the way that it's been modified is working as intended.

38:38.47

Matt Brandenburg

Absolutely and Liz anything you wanted to add on there.

38:41.70

Liz Metzger

Yeah I mean yeah I mean like to build on Stacy's last comment like pick good assessments if you're going to be doing an intervention that addresses depression. It sounds obvious but like. Pick a depression skill that you're actually going to use to measure this because you're doing your own mini research study on every single patient to some extent and you won't build your own knowledge of what works or doesn't unless you're collecting good outcome measures.

39:05.64

Matt Brandenburg

Absolutely I really appreciate the care that was put into facilitating the translation of interventions to practice within the practice guidelines. I think 1 thing that's really helpful. Stacy you mentioned this earlier. You. Include billing codes in your case studies, and are really taking these next steps to help the reader and the user apply what they're learning and apply what they're seeing related to the evidence to their everyday practice. I want to ask you if you could share you know a case study or an aspect of the practice guideline that you really enjoy. , that could ah facilitate that translation of evidence to practice for its readers.

39:53.86

Liz Metzger

Well building on the building codes we included the new caregiver education codes that are going to be taking effect in 2024 and honestly it was a challenge because they had never existed before so we were really excited to practice them and make sure that we were doing it correctly. , so that clinicians know how to apply them because we were excited that this is a new code that there's a recognition that we can bill for specifically caregiver education. Even if the patient isn't present so we want to make sure that clinicians know how to do that and feel confident using that code because we know if we don't use it. They're going to take it away from us, so I'm really excited about that and in general , Stacy and I took a lot of care in creating the case studies they're based on many real patients that I've had over the years and I mean we obviously multiple patients that multiples of us have had over the years and we had ah a fun. It was a fun process to identify the interventions and applying the research there. So like if you're looking at how to apply the research via interventions I think that piece is really nicely translated for clinicians.

41:05.64

Stacy Smallfield

And there's variety in the two cases. So one is a case where the person with Alzheimer’s disease is living at home with a care partner and all of the things that go into the occupations at home and. What the care partner is experiencing and then the second case is an adult. who has already transitioned to skilled nursing and then is having some more progression of the dementia and so you can see. Ah, examples of how to do things to address the depressive symptoms and how to incorporate a physical activity program and a sensory activities like showering music again. Physical activity passive range of motion and how to train. Caregivers or care partners. Both family members that visit but also the staff at the facility. How good training can also reduce the work of their care make it easier for them to care. For the person. So I like the variety of the cases and the interventions intervention ideas things that can be incorporated into intervention that that are of course are grounded in the evidence.

42:41.36

Matt Brandenburg

Absolutely I Think if you work with this population and read through and work through those cases. There's so many nuggets and valuable examples that are going to Spark creativity and you know generate light bulb moments for practitioners I imagine just like oh Wow like. I can try this with you know these 3 clients and ah it's such a valuable resource it's about time to wrap up but I want to ask what additional resources related to the practice guidelines or best practice in general for working with adults who have Alzheimer’s disease and related neurocognitive disorder would you recommend to our listeners.

43:25.80

Liz Metzger

I will always advise people to start at the Alzheimer’s Association just because especially they have amazing resources for care partners. They are staying up to date on evidence. Overall, they have great handouts, they have obviously their 24 hour hotline which I will always provide to family members for individual, especially if they're living at home if they're care partners, but yeah, that's my number 1. Stacy what else do you got.

43:55.31

Stacy Smallfield

Well, that's really great advice. It's hard to beat that I think in general, if we think about how best to take care of ourselves anytime right? Exercise nutrition sleep Stress management. Social participation having some mindfulness time for mindfulness right? We do all of those things to take care of ourselves and maintain our own self-care and that translates to anyone we're working with so making sure again habit and routine as best. Possible addressing exercise sleep managing stress social time those you you just can't go wrong I think.

44:44.47

Matt Brandenburg

I love that those are wonderful recommendations and resources, and I'll make sure to link the Alzheimer’s association in our episode description. So our listeners can check that out, we end every show with the golden nugget segment. And I just have one last question for you both if you could share one piece of advice or 1 recommendation with practitioners. What would it be.

45:11.80

Liz Metzger

Ah, keep it person Slash care partner centered.

45:15.87

Stacy Smallfield

And mine would be build in Habit and routine.

45:23.56

Matt Brandenburg

I love that I think AOTA should start selling stickers with those slogans I would wear them both on my water bottle

45:30.30

Stacy Smallfield

That's great.

45:36.30

Matt Brandenburg

So Great speaking with you today. Thank you for sharing all of your knowledge and giving us a sneak peek into all the work that goes into a practice guideline and sharing how practitioners can really use this resource to up their game. and provide higher quality of care to the clients that they care about and really need it.

45:55.79

Stacy Smallfield

Thanks Matt thanks for all of you all that you do for AOTA and occupational therapy as well. Your just your passion for podcasts and getting that evidence out to People who can use. It is so important and you're making just a really important contribution as well. So thank you for all that you do.

46:22.17

Matt Brandenburg

Well thank you that was really sweet. It's ah it's truly my pleasure and you know it all came from being in your lab and from that first project. So thank you so much.

46:35.26

Stacy Smallfield

You're welcome.

46:38.93

Matt Brandenburg

Stacy Liz do either of you have any questions or concerns anything you want to revisit or rehash before we stop the recording.

46:46.55

Liz Metzger

I feel like I feel like I'd like to mention some of the authors the other authors Stacy would that be all right? so you this may want to go in earlier but obviously we just want to give credit and thanks to our other co-authors.

46:55.60

Stacy Smallfield

and her.

47:02.68

Liz Metzger

Melissa Green Elizabeth Rodis and Laura Henley as well as the amazing people at AOTA especially Beth Hunter and Susan Cahill who have been instrumental in creating this guideline.