WAYNE STATE UNIVERSITY INSTITUTE OF GERONTOLOGY

- 2023 -

Issues in Aging

Monday
April 24
8:00 am - 3:45 pm

REGISTER HERE:
https://shopprod.wayne.edu/iog/iog

alzheimer's association
THE BRAINS BEHIND SAVING YOURS.

Fair Enough: Equity, Care & Safety for Our Most Vulnerable

LIVE EVENT: JOIN US IN-PERSON!

6 CREDITS for Social Workers, Nurses, Occupational Therapists, Physical Therapists, Case Managers, and General Certificate.

$65 for Professionals
$40 for Students, Older Adults, Family Caregivers

Breakfast & buffet lunch are included!
Prepared by the skilled students of Schoolcraft College Culinary Arts Program

LOCATION
VisTaTech Center
Schoolcraft College
18600 Haggerty Rd.
Livonia, MI 48152

AGENDA

8:00 am – Light Breakfast, Vendor Tables
8:30 am – *Alzheimer's Disease in African Americans*, Q & A
10:00 am – Break, Networking, Vendor Tables
10:30 am – *Financial Vulnerability, Exploitation & Wealth Loss*, Q & A
NOON – Lunch
12:45 pm – *Talking with Older Adults about Alzheimer's testing*, Q & A
2:00 pm – *Healthcare Help for Caregivers of Frail Older Adults*, Q & A
3:30 pm – Closing, Raffle Drawings

– details on next page –

Thank you to the following organizations for their support of this conference

PREMIER PARTNER
Alzheimer's Association of Michigan

SUPPORTERS
Allegria Village
Area Agency on Aging 1-B
BrightStar Care
Center for Financial Planning
CorsoCare & Affiliates
Heart to Heart Hospice
Henry Ford Health Systems
Jewish Family Services
Jewish Senior Life
PACE of Southeast Michigan
Presbyterian Village of Michigan
ProMedica Senior Care
Senior Caregiver Resource Network
Waltonwood Senior Living Communities

Lisa L. Barnes, PhD
Alla V. and Solomon Jesmer Professor of Gerontology and Geriatric Medicine
Associate Director, Rush Alzheimer's Disease Center

Alzheimer's Disease in African Americans: Current knowledge, challenges and keys to prevention

Research suggests older African Americans are at greater risk of cognitive impairment and Alzheimer's disease. The disparity is often linked to a combination of factors including low socioeconomic resources, low education, and a higher prevalence of vascular conditions like diabetes and hypertension. Dr. Barnes will discuss the reasons for the increased risk in this population and current challenges that limit our progress in understanding the reasons for this disparity.

Peter Lichtenberg, PhD ABPP
Director, Institute of Gerontology
Distinguished Service Professor of Psychology
Wayne State University

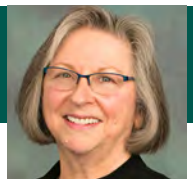
New Methods to Assess Financial Vulnerability, Exploitation and Wealth Loss in Older Adults

New evidence-based tools can help identify who is at heightened risk for financial exploitation and wealth loss. This presentation will focus on the development and validation of these tools and how they can be put into your practice. A new model of financial capacity will also be presented and illustrated through case studies.

Annalise Rahman-Filipiak, PhD
Assistant Professor & Clinical Neuropsychologist
University of Michigan
Michigan Alzheimer's Disease Research Center

Sharing What We Learn: Talking with older adults about the results of Alzheimer's testing

How health information is communicated, such as a new diagnosis of mild cognitive impairment or dementia – Alzheimer's type, is an important predictor of wellbeing and how well medical recommendations are followed. The sensitive disclosing of these results can also be a tool for building rapport with patients and research participants, especially when it enlists bi-directional communication and partnership.
Dr. Rahman-Filipiak will review the current literature about providing neuropsychological and diagnostic feedback to older adults and families and outline the challenges in disclosing information about Alzheimer's disease biomarkers to patients.



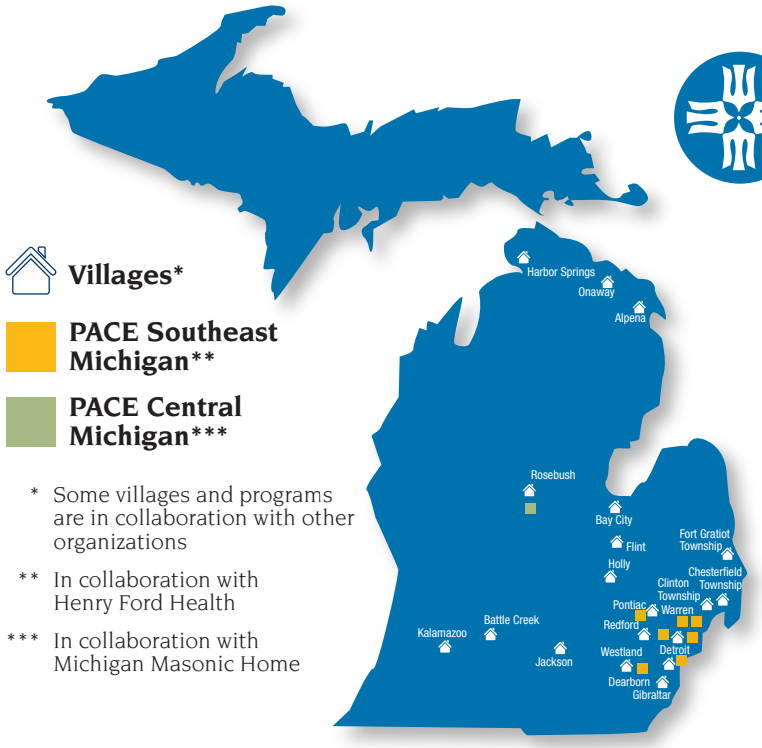
Terri Harvath, PhD RN, FAAN, FGSA
Clinical Professor, School of Nursing
University of Minnesota

Healthcare Help for Family Caregivers of Frail Older Adults

Family caregivers of frail older adults often find they must interact with healthcare professionals more than usual. These stresses can strain personal and professional relationships and impact quality of care. How can healthcare professionals partner more effectively with family caregivers of frail older adults? Dr. Harvath will describe how to identify a family caregiver, how to assess the caregiver to determine what assistance or support is needed, and how to help them navigate some of the ethical dilemmas they encounter in their family caregiving role.

REGISTER AT: https://shop.prod.wayne.edu/iog/iog

WAYNE STATE UNIVERSITY



Villages*

PACE Southeast Michigan**

PACE Central Michigan***

* Some villages and programs are in collaboration with other organizations

** In collaboration with Henry Ford Health

*** In collaboration with Michigan Masonic Home

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PACE Locations
Offer the Program of All-Inclusive Care for the Elderly (PACE). Provides care and services in the home, community and the Day Health Center.

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PACE Central Michigan
www.pacecmi.org
(833) 532-6981

There are many PVM Communities throughout Michigan:

Perry Farm Village, Harbor Springs	**231.526.1500**
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The Village of Oakman Manor	**313.957.0210**
The Village of St. Martha's	**313.582.8088**
The Village of University Meadows	**313. 831.6440**
The Village of Woodbridge Manor	**313.494.9000**
The Village of Gibraltar Manor, Gibraltar	**734.676.4802**
Lynn Street Manor, Onaway	**989.733.2661**
McFarlan Villages, Flint	**810.235.3077**

baldwinsociety.org

SUPPORT OLDER ADULTS IN NEED

Aging successfully on a fixed income in today's world is tougher than ever. Did you know that many critical daily essentials are generally NOT covered by Medicare and/or Medicaid? Many of these daily necessities can make the difference in older adults remaining safe and independent.

OUR MISSION:
Our mission is to support under-served older adults in need today and to invest in meaningful research for a better tomorrow.

WHAT WE DO:
As a 501(c)3 non-profit organization, we have two main areas of focus: Outreach & Research.

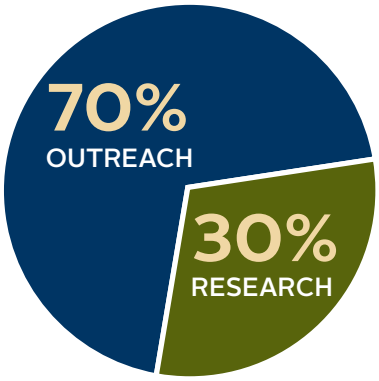
OUTREACH:
We provide micro-grants to Michigan's income-eligible older adults ages 55+ through partnerships with vetted community agencies and organizations. Applications for grants can be submitted by qualified partners here for review.

RESEARCH:
We invest in research that covers a wide variety of issues relating to older adults through partnerships with universities and research centers.

$2.7 million
raised over 13 years

3,100 seniors
served in 2020

15 community partners
& growing



Baldwin Society is the only non-profit created solely to address the gaps between government subsidy programs and services and what seniors actually need to remain independent.

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BaldwinHouseSeniors.com

The Baldwin Society is the philanthropic arm of Baldwin House Senior Living. Baldwin House combines care with compassion and dignity. We offer families peace of mind and give seniors who call Baldwin House home the freedom to live their very best lives. Call us today to find out more!

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(248) 335-7020

Support for caregivers like you

Contact the Henry Ford C.A.R.E. Program℠

(Caregiver Assistance Resources and Education Program)

Support groups and classes are being offered virtually with the option to join by phone, tablet, iPad, or computer.

Contact us by:
henryford.com/familycaregivers
Toll free number: 866.574.7530
Email: CaregiverResources@hfhs.org

Join our Facebook group, "Henry Ford Health Family Caregivers," and become part of an online community of caregivers.

HENRY FORD HEALTH®

Please join us for the Michigan Alzheimer's Disease Research Center's 7th Annual

Beyond Amyloid Research Symposium

Friday, May 19, 2023
8:30 a.m. - 4:30 p.m.

Wayne State University
Student Center Ballroom
Floor 2
5221 Gullen Mall
Detroit, MI 48202

Registration is required at michmed.org/QRRZY

Now accepting abstracts!

Studies of any topic relevant to Alzheimer's disease and related dementias are welcome. Please submit abstracts of 250 words or less by Friday, April 28 within the Eventbrite registration platform.

Michigan ADRC
Alzheimer's Disease Research Center

8:30 a.m. **Breakfast, Registration and Poster Set-up**

9:00 a.m. **Welcome**
Peter Lichtenberg, Ph.D. – Director, Institute of Gerontology, Wayne State University

9:05 a.m. **An Update on the Michigan ADRC**
Henry Paulson, M.D., Ph.D. – Director, Michigan Alzheimer's Disease Center

9:15 a.m.
Keynote Presentation
"Understanding Vascular Contributions to Cognitive Impairment and Dementia (VCID) through Forward and Backward Translation"
Donna Wilcock, Ph.D. – Robert P. and Mildred A. Moores Endowed Chair in Alzheimer's Disease, Sanders-Brown Center on Aging, University of Kentucky

10:00 a.m. **Coffee Break and Poster Viewing**

11:00 a.m.
Keynote Presentation
"Changes in Brain and Cognition During the Preclinical Phase of Alzheimer's Disease: Findings from the Wisconsin Registry for Alzheimer's Prevention (WRAP)"
Sterling Johnson, Ph.D. – Jean R. Finley Professor of Geriatrics and Dementia, Department of Medicine, Geriatrics and Gerontology Division, University of Wisconsin

11:45 a.m.
Neuroplasticity in Aging: Effects of Cognitive Training and Neuromodulation
Alexandru Iordan, Ph.D. – University of Michigan

12:05 p.m. **Lunch and Poster Viewing**

1:15 p.m.
Keynote Presentation
"ADRD Disparities and their Impact on Distal Healthcare Outcomes"
Wassim Tarraf, Ph.D. – Associate Professor, Institute of Gerontology and Department of Healthcare Sciences, Wayne State University

2:00 p.m.
Bugs, Blood, and Brains: Plasma-derived Bacterial Extracellular Vesicles and their Potential Roles in Alzheimer's Disease and Related Dementias
Kelly DuBois, Ph.D. – Michigan State University

2:20 p.m. **Coffee Break and Poster Viewing**

3:00 p.m.
Discrimination of Healthy Controls and Patients with Mild Cognitive Impairment based on Resting-State EEG
Tongtong Li, Ph.D. – Michigan State University

3:20 p.m.
Discovery of a Novel Endomembrane Recycling Pathway Critical for Synaptic Function
Pilar Rivero-Rios, Ph.D. – University of Michigan

3:40 p.m.
Metals Exposure, Dementia, and Longitudinal Trajectories of Cognition, Functioning, and Neuropsychiatric Symptoms
Xin Wang, Ph.D., M.P.H. – University of Michigan

4:00 p.m. **Closing Remarks and Poster Awards**

Join us at the Michigan Alzheimer's Disease Research Center

The Michigan Alzheimer's Disease Research Center is committed to memory and aging research, clinical care, education, and wellness.

The center collaborates with other research institutions across the state including Wayne State University and Michigan State University, as well as local outreach organizations including the Alzheimer's Association to enhance groundbreaking research efforts and community education. The center is also one of 33 other National Institutes of Health-funded Alzheimer's Disease Research Centers across the country.

Michigan ADRC

alzheimers.med.umich.edu
UM-Ask-MADC@med.umich.edu
734-936-8803
@umichalzheimers

Interested in getting involved in research studies?

Please call Kate Hanson at 734-936-8332 or visit alzheimers.med.umich.edu/research for a list of currently enrolling studies.

Interested in learning about upcoming educational events?

To stay informed of upcoming events, please email Erin Fox at eefox@med.umich.edu to subscribe to our monthly e-newsletters.

Interested in learning more about our wellness programs?

Please call Ashley Miller at 734-615-8293 or visit alzheimers.med.umich.edu/wellness-initiative.

Interested in learning about our Lewy body dementia programs?

Please contact Renee Gadwa at 734-764-5137 or visit alzheimers.med.umich.edu/lbd.

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AFU Age-friendly University Global Network

Wayne State University has been designated as an Age-Friendly University (AFU), yet another important step toward ensuring that opportunity remains equitable campus-wide. The Age-Friendly University Global network is an innovative consortium dedicated to promoting diversity, equity and inclusion within higher education and confirms that combating ageism is an important dimension of that strategy.

WAYNE STATE UNIVERSITY

Institute of Gerontology

NO COST ONE-ON-ONE ASSISTANCE

Are you currently providing care for an older adult family member? Do you have personal or caregiver related financial management challenges?

We provide free financial coaching to caregivers of older adults. You can receive assistance with issues such as: *Credit Repair, Budgeting, Record-keeping, Scam or Identity, Theft Recovery* and more.

SAFE

For more info contact: **LaToya Hall** at **l.hall@wayne.edu or 313-664-2608.**

Successful Aging thru Financial Empowerment (SAFE) and its research is supported by grants from: National Institute of Justice, Foundation for Financial Health, Michigan Aging and Adult Services PREVNT program, Michigan Health Endowment Fund, State of Michigan, Wayne State University Technology Commercialization, American House Foundation and the Mary Thompson Foundation.

Memory may fade. But love and care shine on.

At BrightStar Care®, we combine expertise with compassion and understanding to enhance the lives of people with memory loss.

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Jewish Senior Life is a vibrant community where the bonds of friendship are built, and passions are pursued. It's a place where older adults can embrace life and community, staying connected to the relationships and places they enjoy.

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INSTITUTE OF GERONTOLOGY

The WALLET Study: A Study of Memory Change and Money Management

Because the links between early memory loss and a decline in wealth are on the rise, the WSU Institute of Gerontology is seeking to interview older adults aged 60+.

The interview will examine financial decision-making and financial management as well as completion of cognitive tests and other measures. A review of financial records from a primary checking account and credit card account will be included. Interviews will be scheduled at your convenience.

Participants will be **compensated**

All financial records will be de-identified and information kept **confidential**

Interviews will take place **over the telephone**

Peter Lichtenberg, PhD
Principle Investigator and Director
of the Institute of Gerontology
Wayne State University

If interested,
contact Vanessa Rorai at
313-664-2604
or **vrorai@wayne.edu**

The WALLET Study: Wealth Accumulations & Later-life Losses in Early cognitive Transitions

What to expect if you participate in the study:

1. Vanessa Rorai will ask you screening questions to determine if you are eligible to participate in the study.
2. If you are eligible, Vanessa will send you our consent form that describes in detail all aspects of the study for your review.
3. After you review the consent form and agree to participate, Vanessa will begin the process of obtaining 12-months of bank statements.
4. Once Vanessa receives the bank statements she will completely de-identify all bank records. She will then contact you to schedule two interviews. The interviews can be done via telephone or video call. Interviews are scheduled based on your availability and typically within a week of receiving the bank statements..
5. The first interview is with Vanessa, it will take approximately 45 minutes. She will ask questions about your physical and mental health, feelings of stress, and how you are organized financially.
6. The second interview is with Peter Lichtenberg, it will take approximately 1 hour. He will ask more in-depth questions about financial decision-making, financial management, and your cognitive health.
7. After the interviews are completed, Vanessa will send you a compensation form to sign. Once she receives the signed form we will mail you a check for$100 and your participation in the study is complete.

Institute of Gerontology

WAYNE STATE UNIVERSITY

Alzheimer's Disease in African Americans: Current Knowledge, Challenges and Keys to Prevention

Lisa L. Barnes, PhD
Alla & Solomon Jesmer Professor of Gerontology
and Geriatric Medicine
Associate Director, Alzheimer's Disease Research Center,
Rush, Alzheimer's Disease Center

Existing research suggests that older African Americans are at greater risk of cognitive impairment and Alzheimer's disease. The disparity is often linked to a combination of factors including low socioeconomic resources, low education, and a higher prevalence of vascular conditions like diabetes and hypertension among African Americans. This presentation will present what is currently known about the reasons for the increased risk in this population and some of the current challenges that limit our progress in understanding reasons for the disparity. We will also discuss factors linked to being a racial minority that may account for some of the disparities. Finally, we will present some key prevention strategies that can be incorporated to help prevent the loss of cognition in old age.

Alzheimer's Disease in African Americans: Current Knowledge, Challenges, and Keys to Prevention

LISA L. BARNES, PHD

Alla V. & Solomon Jesmer Professor of Gerontology and Geriatric Medicine

Associate Director, Rush ADRC

Rush Alzheimer's Disease Center

Rush University Medical Center, Chicago, IL

1

Outline

- Discuss evidence that suggests African Americans have a greater risk of cognitive impairment and Alzheimer's dementia
- Challenges in understanding greater risk
- Describe risk factors for cognitive impairment in older African Americans
- Evaluate key prevention strategies to protect brain health in old age

2

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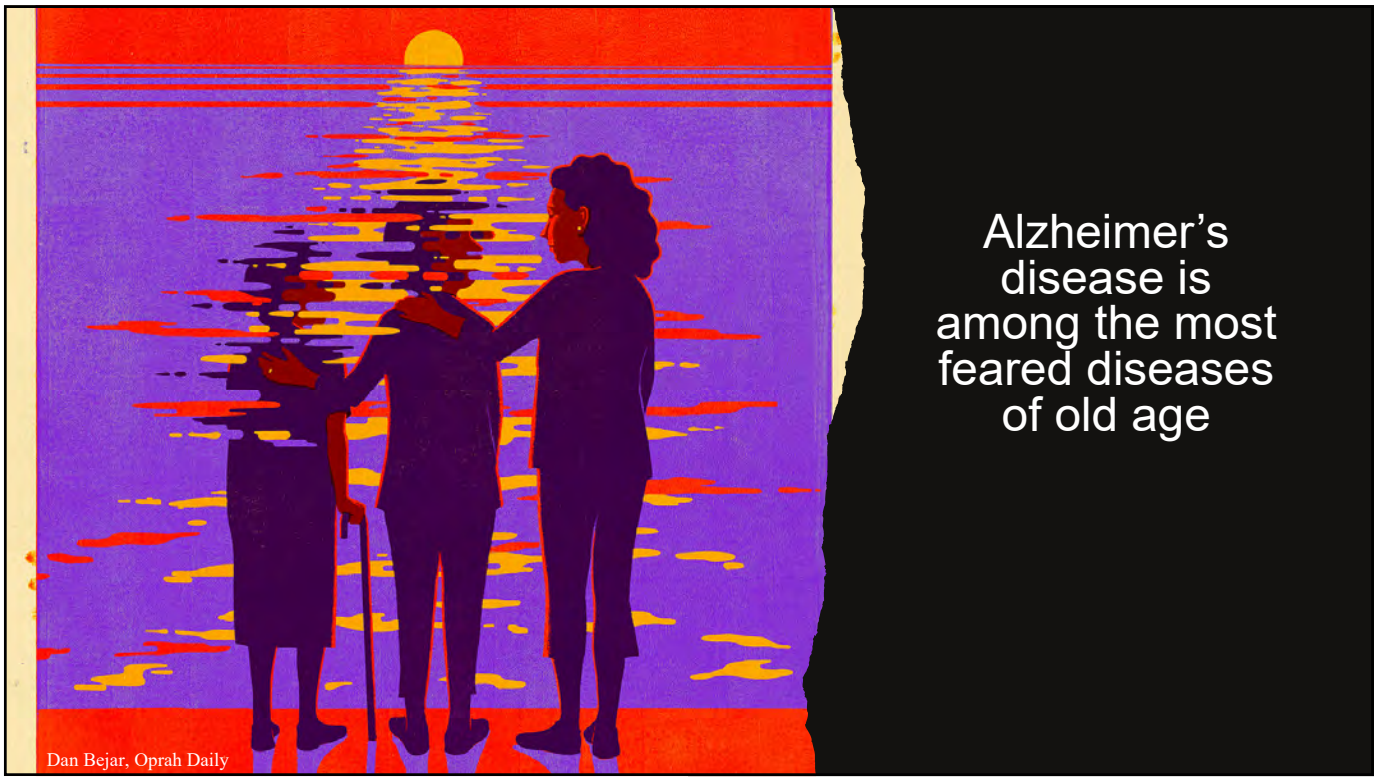
Alzheimer's disease is among the most feared diseases of old age
Dan Bejar, Oprah Daily

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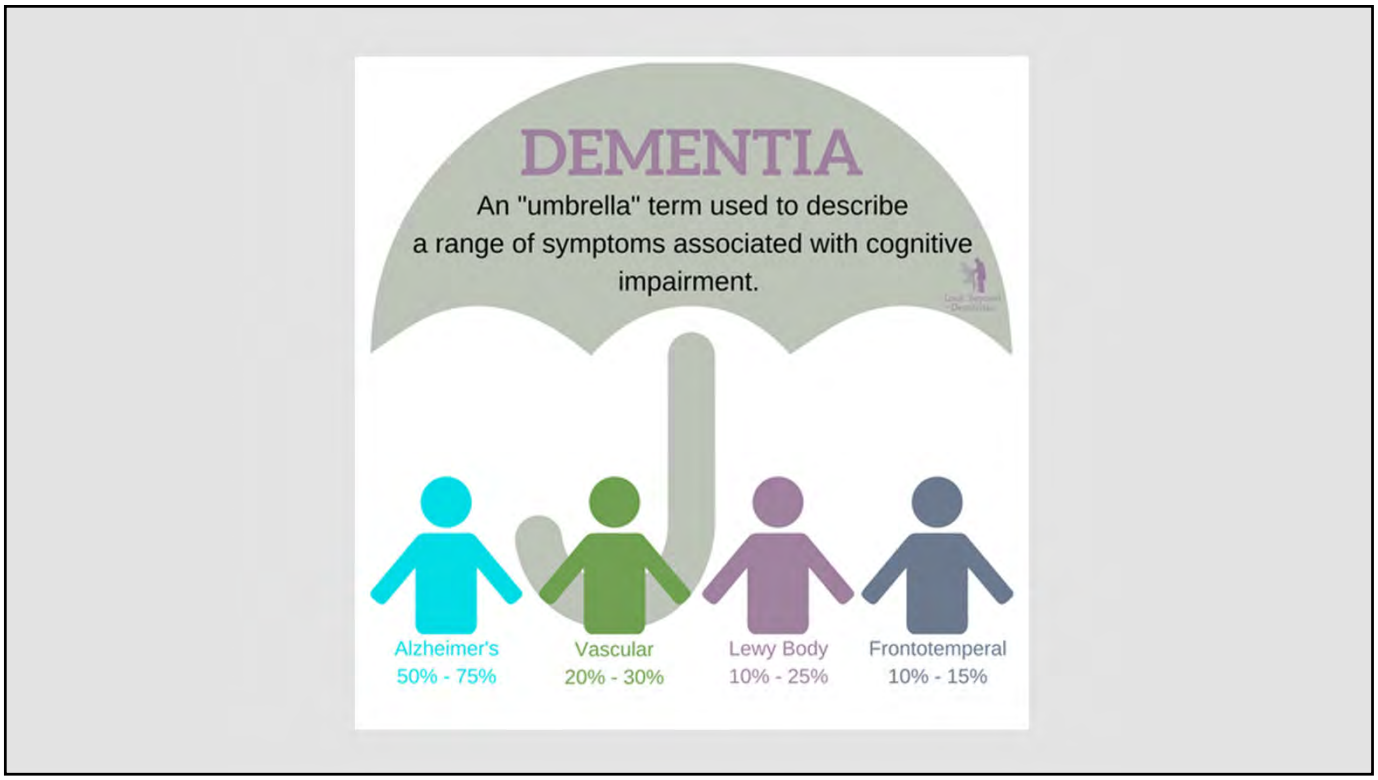

DEMENTIA
An "umbrella" term used to describe a range of symptoms associated with cognitive impairment.
Alzheimer's
50% - 75%
Vascular
20% - 30%
Lewy Body
10% - 25%
Frontotemperal
10% - 15%

4

Auguste D.

5

A Characteristic Disease of the Cerebral Cortex, Alois Alzheimer (1906)

From time to time she was completely delirious… seeming to have auditory hallucinations… When the doctor showed her some objects she first gave the right name but immediately forgot everything… In a writing test she repeated syllables, omitted others… In her conversation she used confused phrases…. She did not remember the use of particular objects.

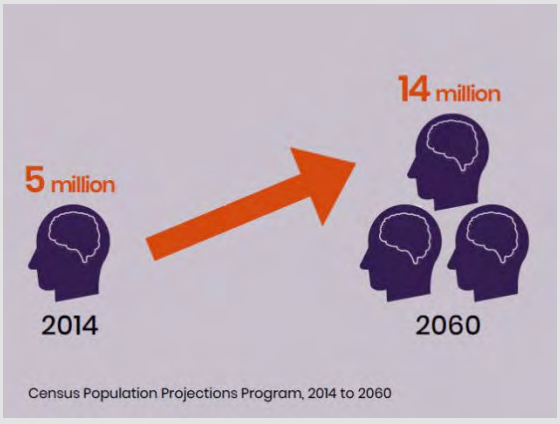
6

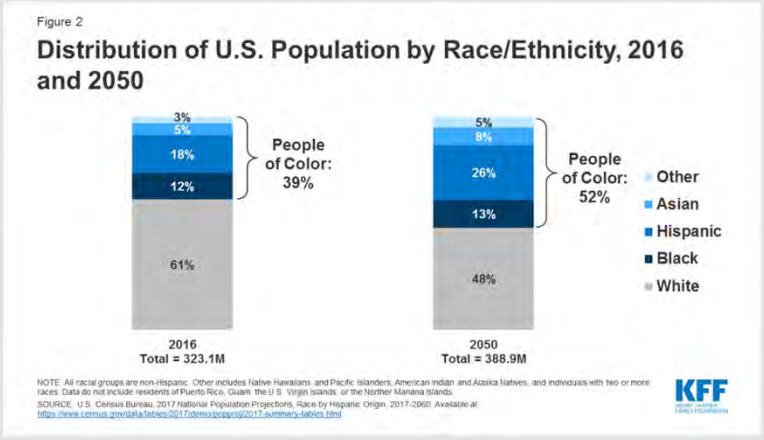
Alzheimer's Disease

- Accounts for 66% of dementia in older adults
- Currently >6 million Americans have AD
  - By 2050, 12-16 million
- 33-50% of adults over age 85 have AD
- Women account for 66% of cases
- AD currently costs $100 billion; and could cost up to $300 billion within 30 years
- Develops over decades, and can affect a person over 3 – 20 years

7

AD has become a public health crisis for an aging population that is also becoming more diverse





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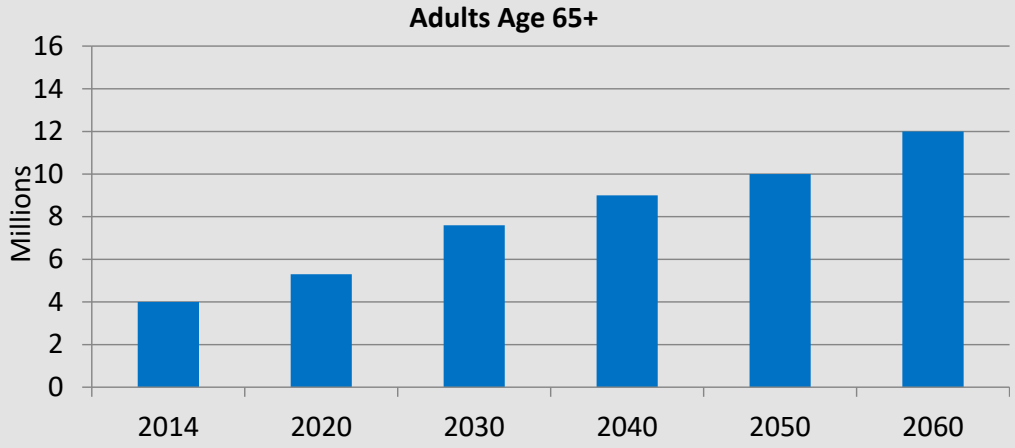
Projected Growth of Older Black Population Between 2014 and 2060



Source: Administration on Aging. A statistical profile of Black older Americans aged 65+. https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2018AA_OAProfile.pdf

9

~ 2x more likely than Whites to have Alzheimer's dementia[1]

Less likely to receive a diagnosis[1]

Diagnosed at later stages[2]

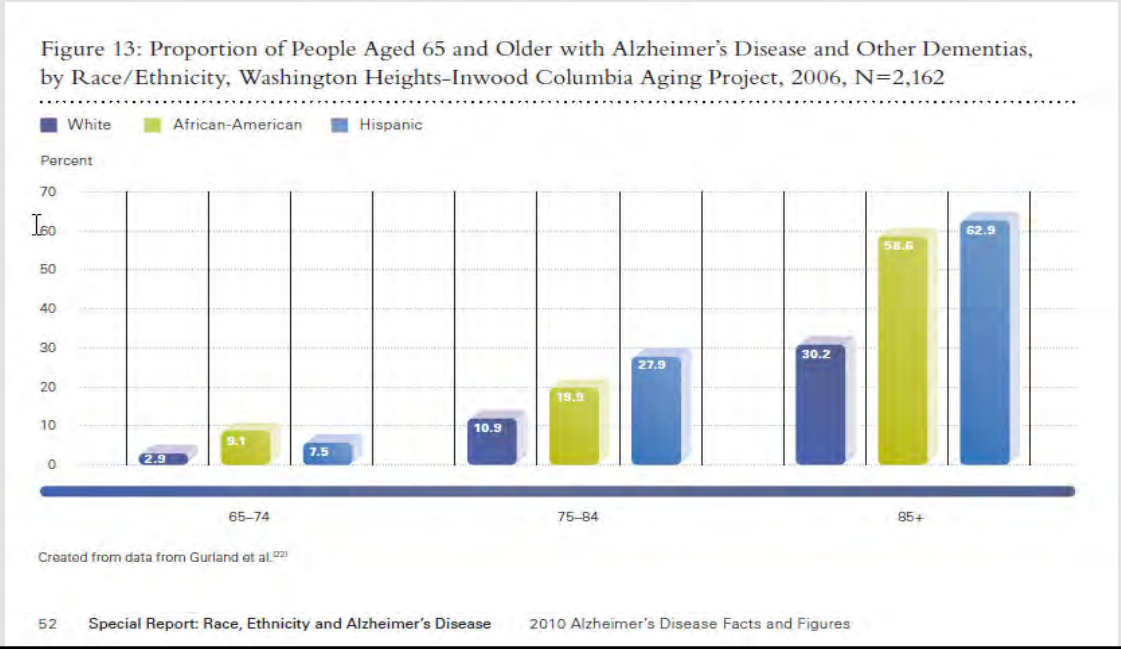
Under-included in ADRD clinical trials[3]

1. Alzheimer's Disease Facts and Figures, 2021
2. Barnes & Bennett, Health Affairs, 2014
3. Kennedy, Cutter, Wang, & Schneider, Am J Geriatr Psychiatry, 2017

10

10

African Americans are about twice as likely to have AD



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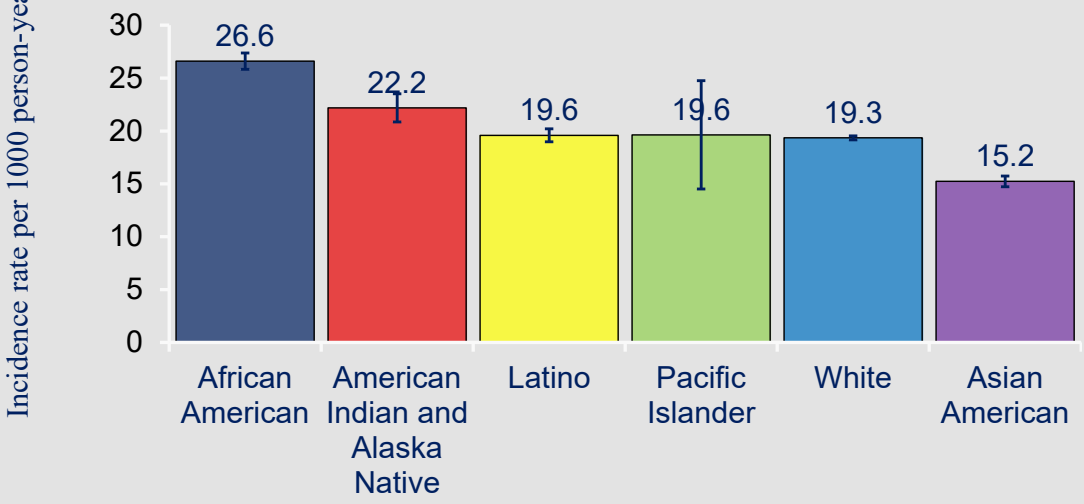
Age-standardized dementia incidence rates by race/ethnicity, 2000-2013



Mayeda et al., Alzheimers Dement, 2016

13

12

Prevalence of AD/MCI higher in African Americans & Hispanic Americans than in White Americans in the Chicago Health and Aging Project

	Clinical AD Prevalence, cases per 100 (95% CI)	Mild Cognitive Impairment Prevalence, cases per 100 (95% CI)
All Participants		
Non-Hispanic White	10.0 (9.6, 10.4)	21.1 (20.8, 21.5)
Hispanic	14.0 (12.0, 16.1)	25.9 (24.5, 27.3)
African American	18.6 (18.0, 19.1)	32.0 (31.7, 32.4)
Overall Prevalence	11.3 (10.7, 11.9)	22.7 (22.3, 23.2)
65–74 Years		
Non-Hispanic White	4.3 (4.1, 4.6)	20.2 (19.9, 20.6)
Hispanic	7.0 (5.8, 8.3)	24.9 (23.5, 26.3)
African American	10.1 (9.6, 10.6)	30.9 (30.6, 31.3)
Age-Specific Prevalence	5.3 (4.9, 5.7)	21.9 (21.5, 22.4)
75–84 Years		
Non-Hispanic White	11.9 (11.3, 12.4)	23.1 (22.7, 23.4)
Hispanic	18.7 (15.8, 21.5)	28.2 (26.7, 29.7)
African American	25.2 (24.5, 25.9)	34.7 (34.3, 35.1)
Age-Specific Prevalence	13.8 (13.1, 14.5)	24.6 (24.2, 25.1)
Over 85 Years		
Non-Hispanic White	31.6 (30.7, 32.5)	20.7 (20.3, 21.0)
Hispanic	44.0 (39.3, 48.7)	25.5 (24.1, 26.9)
African American	54.0 (53.0, 55.0)	31.6 (31.2, 32.1)
Age-Specific Prevalence	34.6 (33.3, 35.8)	22.1 (21.6, 22.5)

Rajan, Weuve, Barnes et al., Alz Dementia, 2021

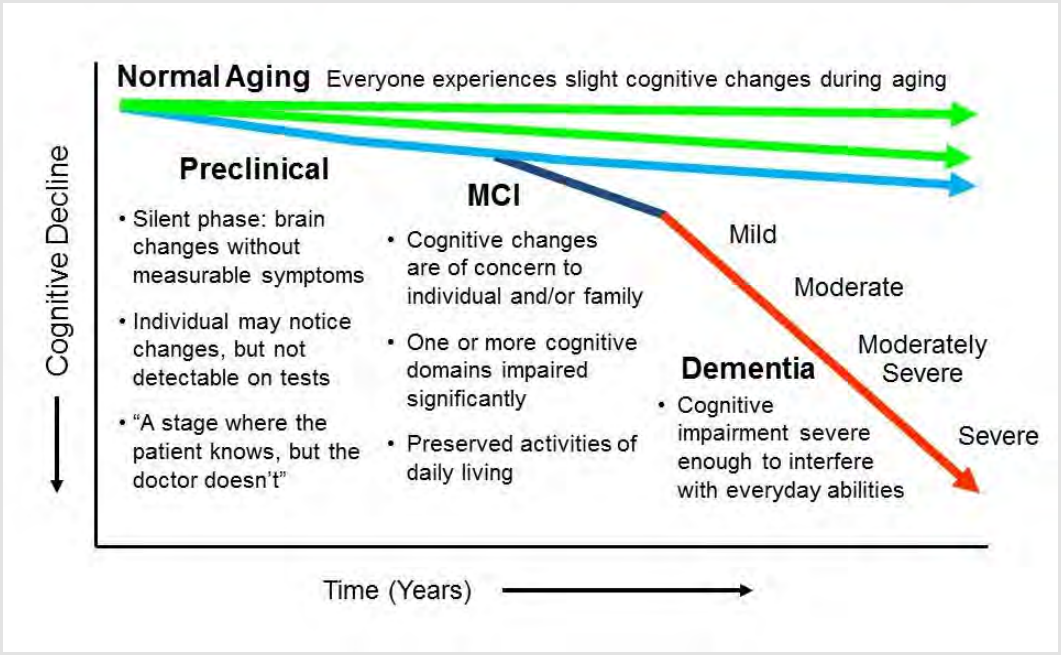
13

Outline

- Discuss evidence that suggests African Americans have a greater risk of cognitive impairment and Alzheimer's dementia
- Challenges in understanding greater risk
- Describe risk factors for cognitive impairment in older African Americans
- Evaluate key prevention strategies to protect brain health in old age

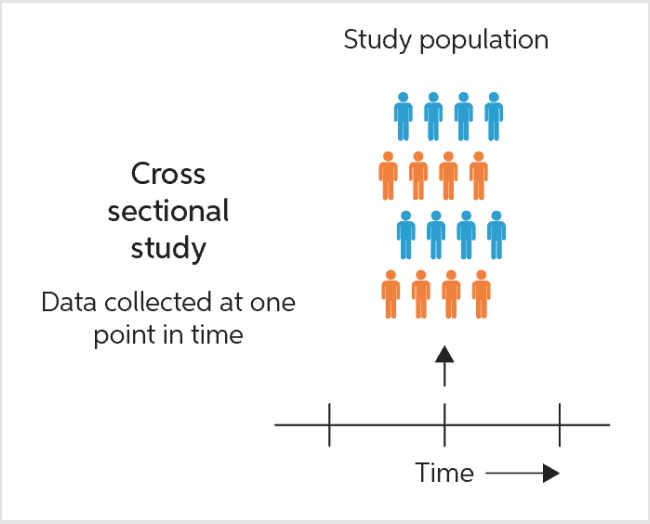
14

14



15

Most studies compare African Americans to other groups in cross-sectional designs



Older African Americans tend to score lower on cognitive function tests

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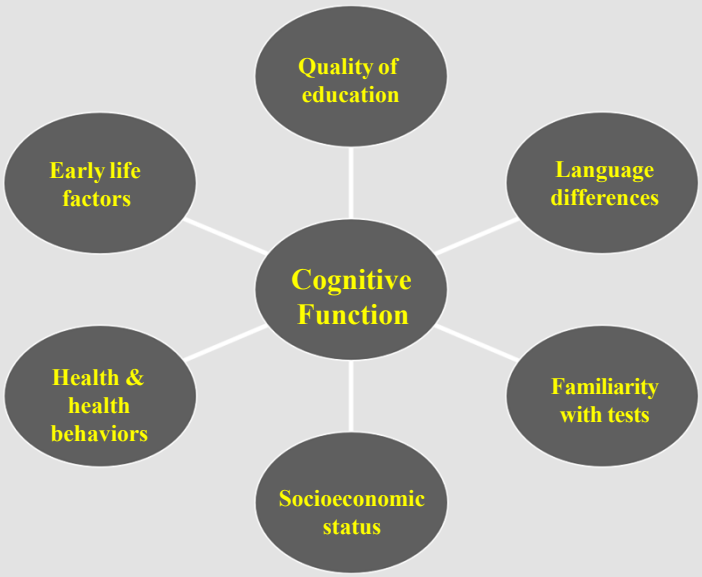
16

COGNITION AND RACE

- Cognition influenced by many factors
- These factors vary by race/ethnicity
- Presents challenges in interpreting racial differences when these tests are used to make a diagnosis



17

FIGURE 20

Percentage of U.S. Adults Who Believe Medical Research Is Biased Against People of Color

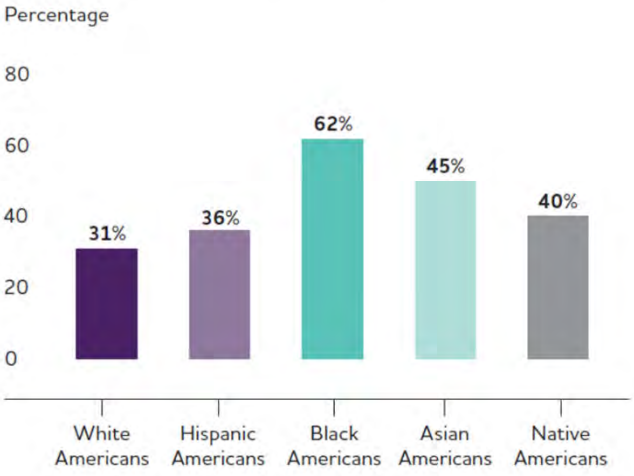
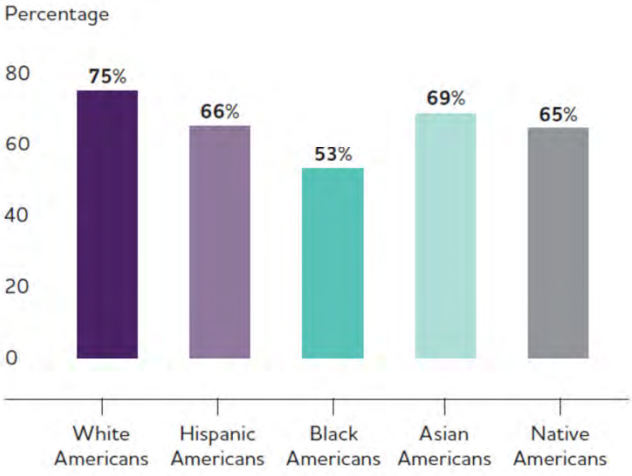


FIGURE 21

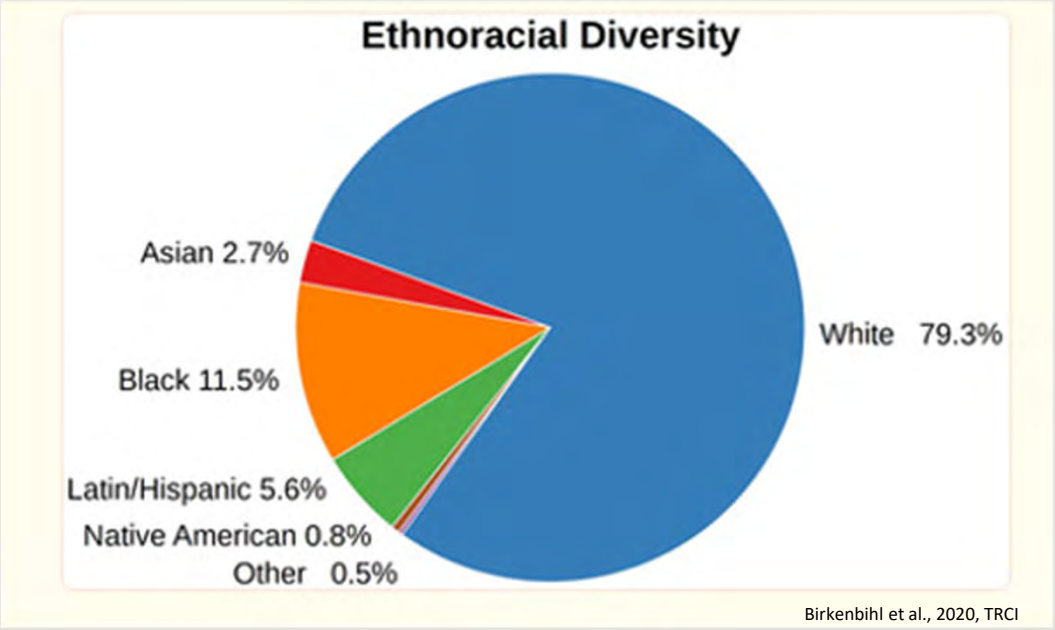
Percentage of U.S. Adults Who Trust an Alzheimer's Cure Will Be Shared Equally Regardless of Race, Color or Ethnicity



2021 Alzheimer's Disease Facts and Figures 18

18

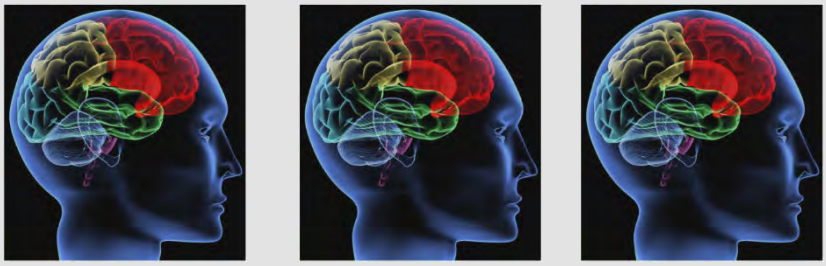
Almost all knowledge about AD comes from studies that are predominantly of White adults



Birkenbihl et al., 2020, TRCI

19

What is needed is longitudinal studies of diverse older adults



Year 1 Year 2 Year 3 Year K

20

A program that centers diversity in cognitive aging research

21

Minority Aging Research Study (MARS)

- Began enrollment in August 2004
- >800 African Americans, >65 years, enrolled without dementia
- Recruited from churches, senior buildings & organizations in Chicago
- Annual in-home cognitive testing, risk factor assessment, and blood draw
- Follow-up rate > 90% among survivors
- ~ 10% have developed Alzheimer's dementia

22

22

Community-Centered Engagement

23

23

Culturally Celebratory Retention Events

24

24

Characteristics of MARS participants

- ~800 self-identified African Americans
- 77% women
- Current mean age = 84 years (SD=8.0)
- Mean education = 14.8 years (SD=3.4)
- >222 deceased
- >376 with MRI
- 55% of alive and active, have agreed to brain donation

25

25

Rush ROS/MAP

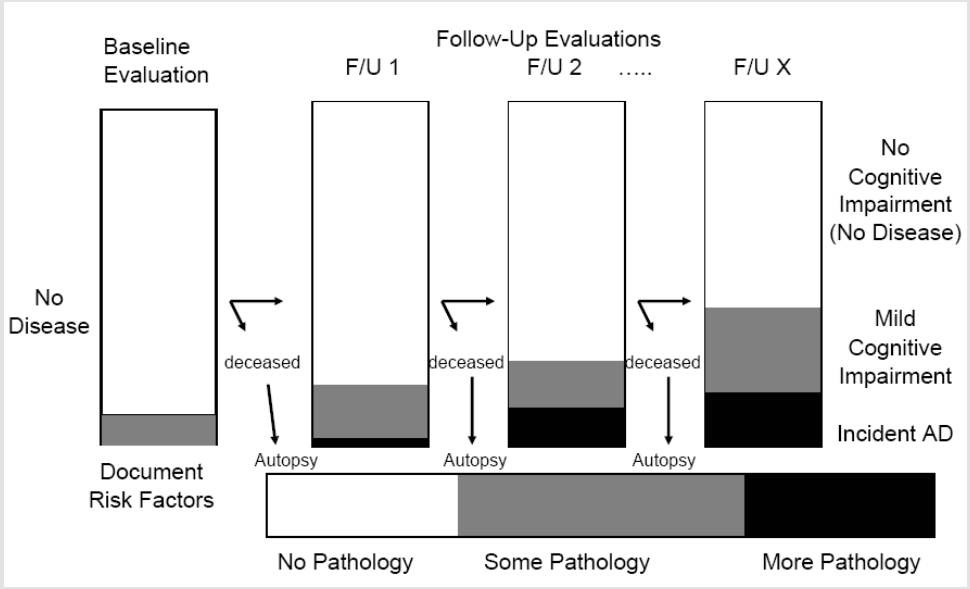
- Two cohort studies of aging and AD ongoing for 20+ years
- >3,700 older persons without [known] dementia from across the USA
- All agreed to annual detailed clinical evaluation for common chronic conditions of aging with detailed evaluation of risk factors, and blood donation
- All agreed to organ donation at death

*Harmonized battery of tests so that we can merge the data

PI: Bennett

26

26

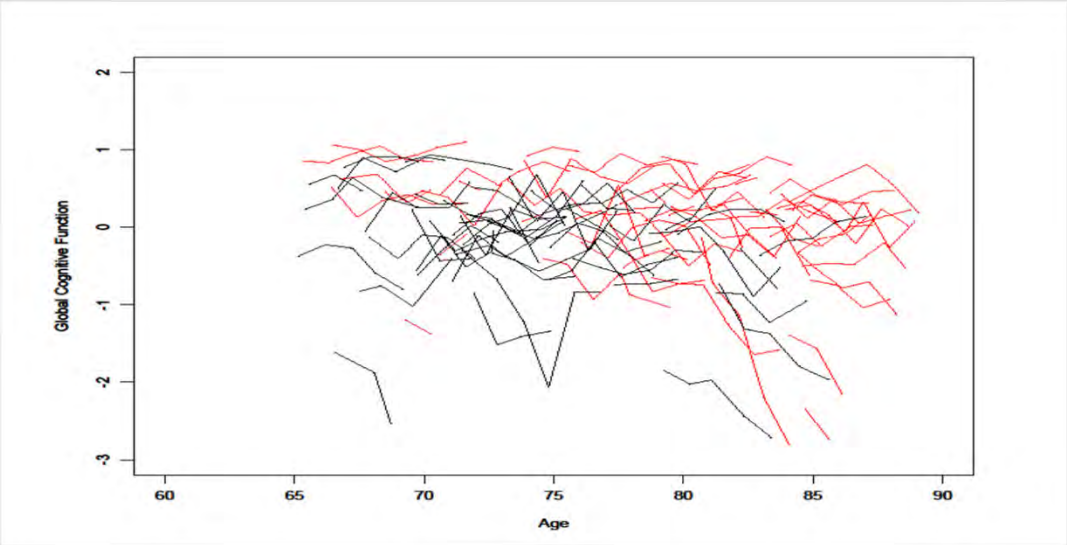


Bennett DA, et al. *Neuroepidemiology.* 2005

27

27

Wide individual differences in where people start and how fast they decline

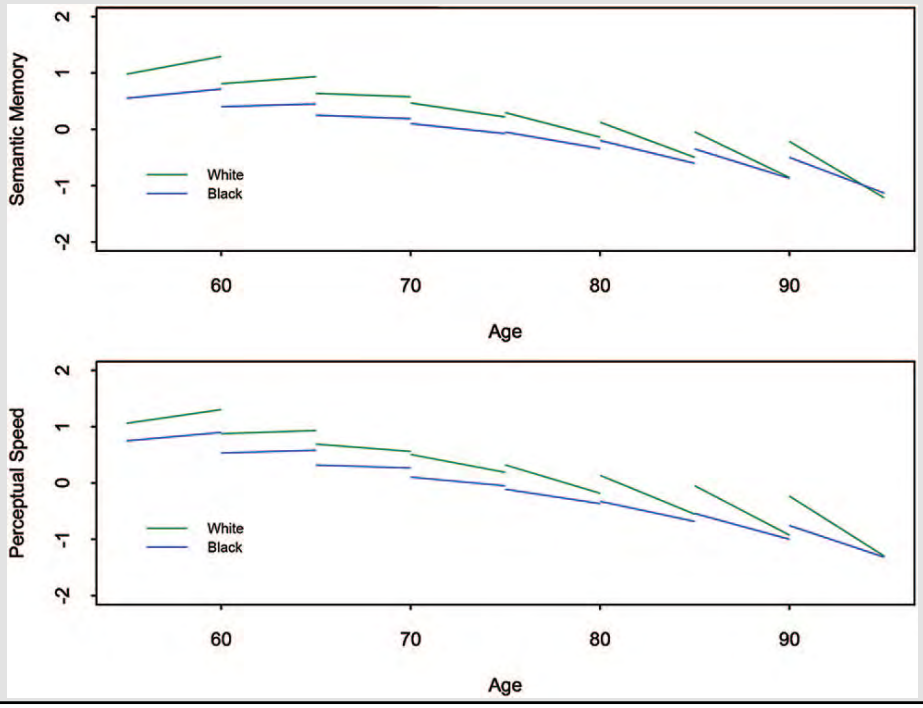


Red – Whites
Black - Blacks

28

28

Despite significant level differences, no differences in decline

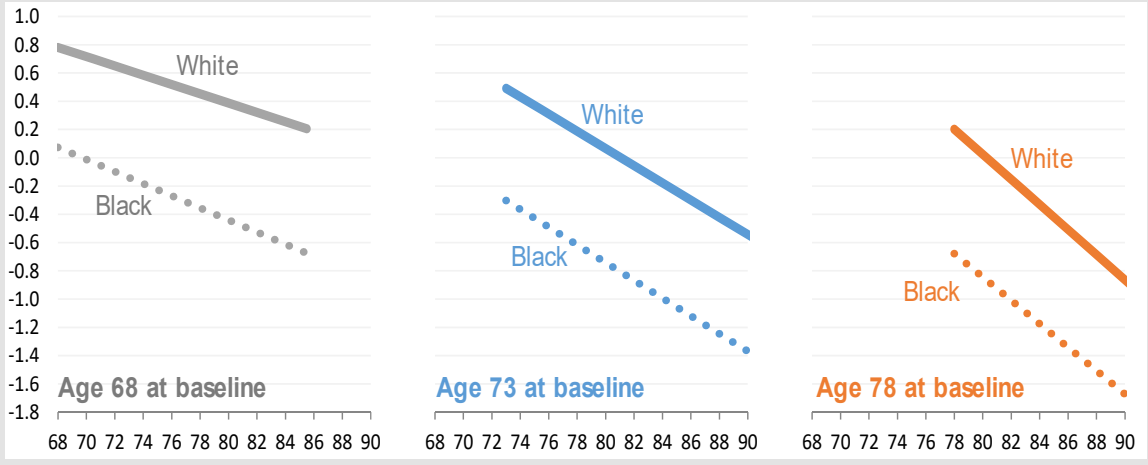


Wilson et al., Psychology and Aging, 2015

29

29

No race differences in rates of cognitive decline in CHAP (population-based)



30

-Some data suggests increased risk of Alzheimer's among African Americans

-No evidence that African Americans are declining at faster rates when we follow people over time

-We do see level differences in where people start, however

Can we identify risk factors that might explain why older African Americans are scoring lower on the cognitive function tests?

31

31

Outline

- Discuss evidence that suggests African Americans have a greater risk of cognitive impairment and Alzheimer's dementia
- Challenges in understanding greater risk
- Describe risk factors for cognitive impairment in older African Americans
- Evaluate key prevention strategies to protect brain health in old age

32

32

Established Risk Factors

Increase Risk

- Age
- Family History
- Genetic mutations
  - Amyloid precursor protein (APP, 21q)
  - Presenilin 1 (PS1, 14q)
  - Presenilin 2 (PS2, 1q)
- Genetic polymorphisms
  - Apolipoprotein E ε4 allele

Decrease Risk

- Education
- Genetic polymorphisms
  - Apolipoprotein E ε2 allele

33

Potentially modifiable risk factors

Increase Risk

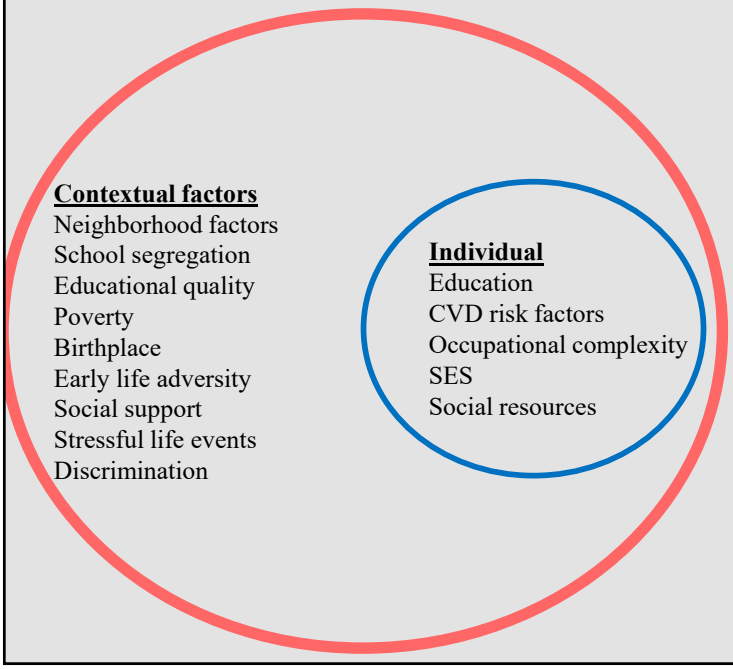
- Cerebrovascular disease (stroke)
- Diabetes
- Hypertension
- Distress proneness
- Loneliness
- Depressive symptoms
- Parkinsonian signs
- Change in BMI (weight loss)
- Olfaction
- Saturated/transunsaturated fats
- Current Smoker

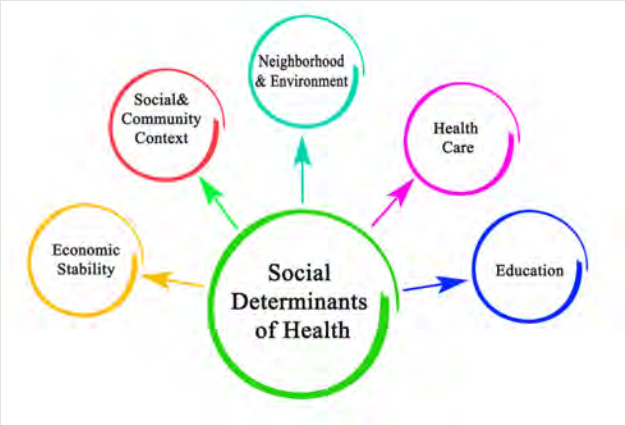
Decrease Risk

- Occupation
- Cognitive activity
- Physical activity
- Social activity
- Social networks
- Omega 3-acids
- Folic acid intake
- Fruits and vegetables
- Mediterranean diet
- Moderate Alcohol intake
- Purpose in life

34

Race is a social construct, shaped by systemic racism





There is no biologic basis of race, and no biologic reason that African Americans are at greater risk

35

35

Studies need to examine risk factors that reflect the lived experience of older African Americans

- Early life residence
- Early life school segregation experience
- Discrimination
- Perceived stress
- John Henryism
- Neighborhood conditions
- Caregiving stress
- Financial burden
- Racial identity
- Spirituality/religiosity
- Occupational complexity

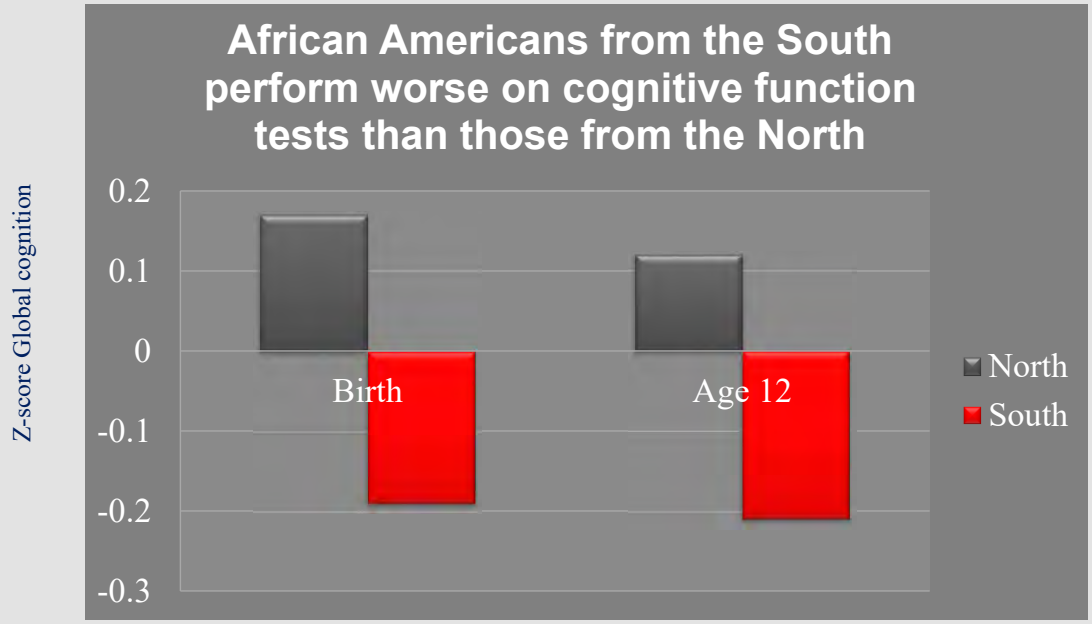
36

Historical context: The Great Migration

37

37

Cognition measured in late-life influenced by where you are born in the US for African Americans



Lamar, Lerner, James, et al., JGPS. 2020

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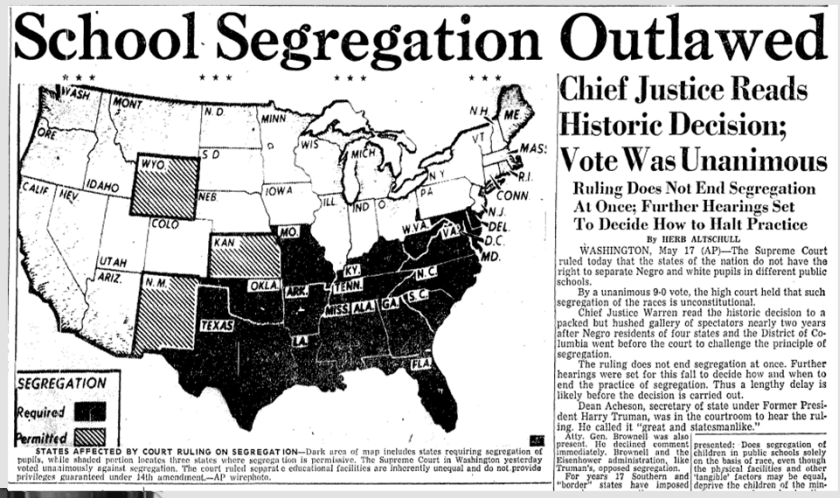
38



School Segregation Outlawed

Chief Justice Reads Historic Decision; Vote Was Unanimous

Ruling Does Not End Segregation At Once; Further Hearings Set To Decide How to Halt Practice

By HERB ALTSCHULL

WASHINGTON, May 17 (AP)—The Supreme Court ruled today that the states of the nation do not have the right to separate Negro and white pupils in different public schools.

By a unanimous 9-0 vote, the high court held that such segregation of the races is unconstitutional.

Chief Justice Warren read the historic decision to a packed but hushed gallery of spectators nearly two years after Negro residents of four states and the District of Columbia went before the court to challenge the principle of segregation.

The ruling does not end segregation at once. Further hearings were set for this fall to decide how and when to end the practice of segregation. Thus a lengthy delay is likely before the decision is carried out.

Dean Acheson, secretary of state under Former President Harry Truman, was in the courtroom to hear the ruling. He called it "great and statesmanlike."

Atty. Gen. Brownell was also present. He declined comment immediately. Brownell and the Eisenhower administration, like Truman's, opposed segregation.

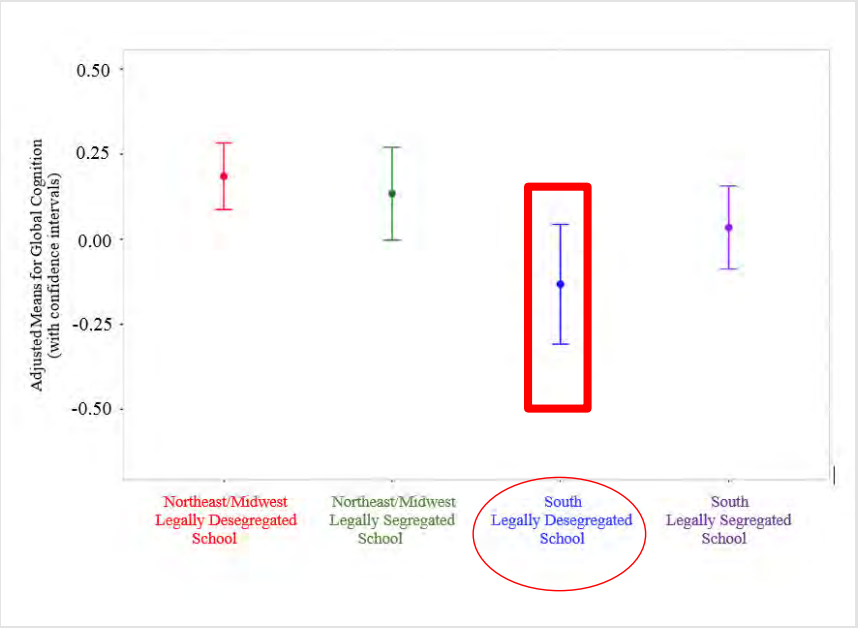
For years 17 Southern and "border" states have imposed presented: Does segregation of children in public schools solely on the basis of race, even though the physical facilities and other tangible factors may be equal, deprive the children of the mi-

SEGREGATION
Required
Permitted

STATES AFFECTED BY COURT RULING ON SEGREGATION—Dark area of map includes states requiring segregation of pupils, while shaded portion locates three states where segregation is permissive. The Supreme Court in Washington yesterday voted unanimously against segregation. The court ruled separate educational facilities are inherently unequal and do not provide privileges guaranteed under 14th amendment.—AP wirephoto.

39

African Americans from the South who attended a desegregated school in early life had lowest cognition in late-life



Lamar, Lerner, James et al., JGPS. 2020

40

Experiences of Discrimination

- Discrimination is an important psychosocial stressor with links to adverse health outcomes
- Some, but not all studies have found it partially explains disparities in health
- Is it associated with brain health?

41

41

"Everyday" Discrimination

- **Self-reported, 9-item scale (Williams et al., 1997)**
  - **People treat you with less courtesy than other people**
  - **People treat you with less respect than other people**
  - **People act as if they think you are not smart**
  - **You receive poorer service than other people at restaurants or stores**
  - **People act as if they are afraid of you**

42

J Int Neuropsychol Soc. 2012 September ; 18(5): 856–865. doi:10.1017/S1355617712000628.

Perceived Discrimination and Cognition in Older African Americans

L.L. Barnes[1,2,3], T.T. Lewis[4], C.T. Begeny[1], L. Yu[1,2], D.A. Bennett[1,2], and R.S. Wilson[1,2,3]
[1]Rush Alzheimer's Disease Center, Rush University Medical Center, Chicago Illinois

Higher reports of discrimination are associated with lower cognition in late-life

Variables	Global cognition	Episodic memory	Perceptual speed
Age	-0.02 (.004)**	-0.03 (.004)**	-0.04 (.005)**
Sex	-0.08 (.052)	-0.17 (.064)*	-0.17 (.076)*
Education	0.07 (.007)**	0.04 (.008)**	0.09 (.010)**
Discrimination	**-0.02 (.010)***	**-0.03 (.013)***	**-0.04 (.015)***

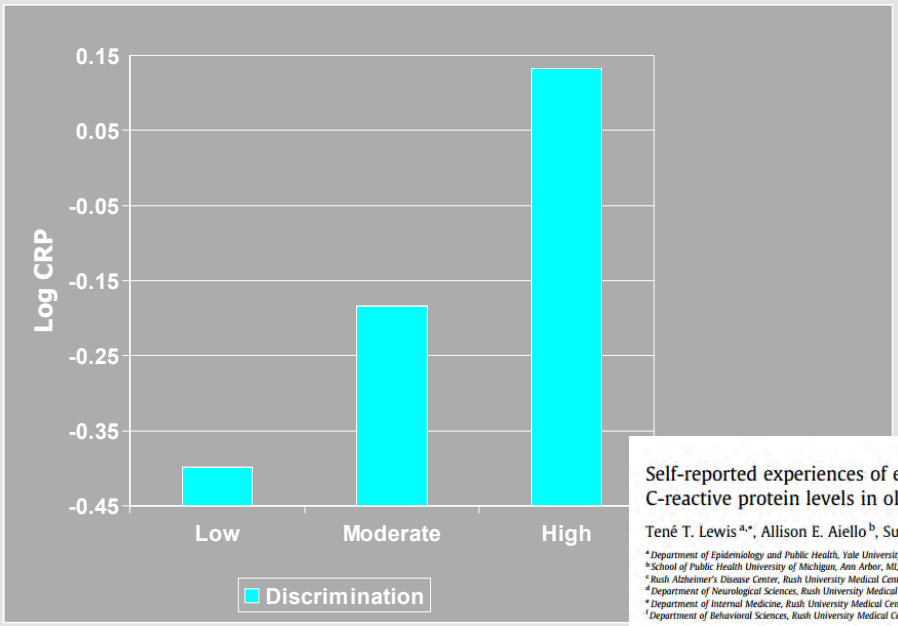
**=p<.01; *=p<.05

Barnes, Lewis, Begeny, et al., JINS. 2012

43

43

Discrimination associated with CRP



Self-reported experiences of everyday discrimination are associated with elevated C-reactive protein levels in older African-American adults

Tené T. Lewis[a,*], Allison E. Aiello[b], Sue Leurgans[c,d,e], Jeremiah Kelly[c,d], Lisa L. Barnes[c,d,f]
[a] Department of Epidemiology and Public Health, Yale University School of Medicine, New Haven, CT, USA
[b] School of Public Health University of Michigan, Ann Arbor, MI, USA
[c] Rush Alzheimer's Disease Center, Rush University Medical Center, Chicago, IL, USA
[d] Department of Neurological Sciences, Rush University Medical Center, Chicago, IL, USA
[e] Department of Internal Medicine, Rush University Medical Center, Chicago, IL, USA
[f] Department of Behavioral Sciences, Rush University Medical Center, Chicago, IL, USA

Lewis, Aiello, Leurgans, et al., Brain Behav Immunity, 2010

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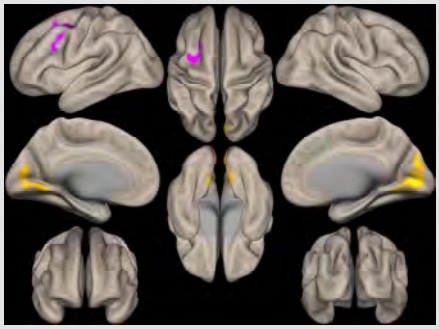
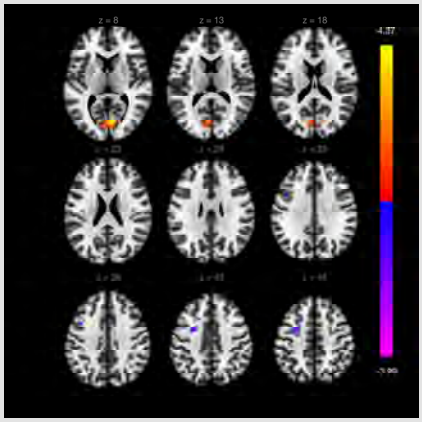
44

Discrimination associated with functional connectivity measured with fMRI





-Associated with less functional connectivity of the left insula to the dorsolateral prefrontal cortex

- Areas involved in trust perception

Han et al., Brain Imaging Behavior, 2020

45

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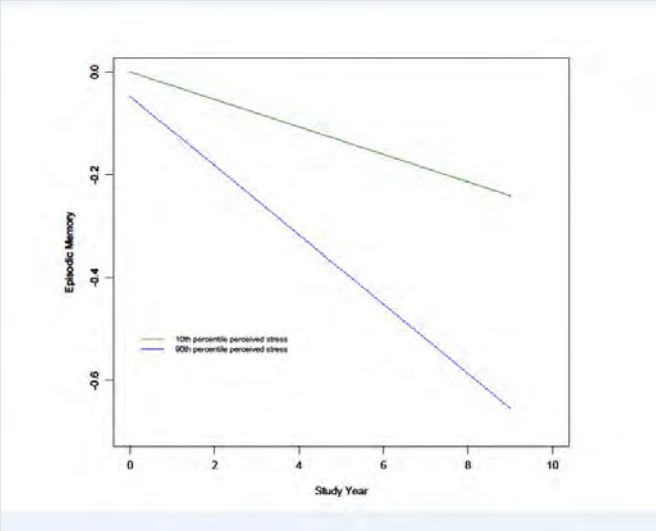
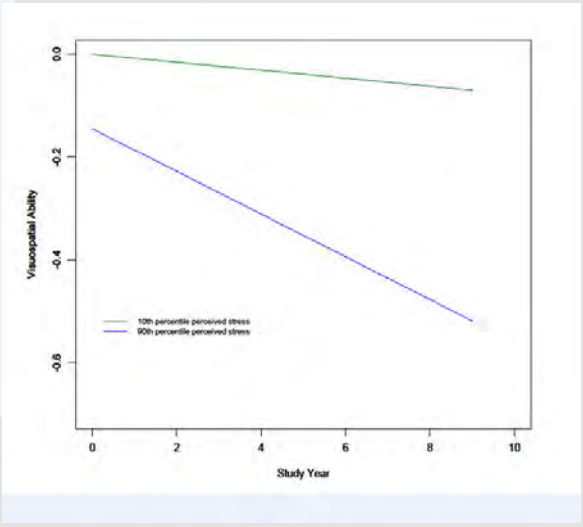
Perceived stress related to faster decline in cognition



Episodic memory

Degree to which one finds their life uncontrollable, unpredictable, overloading



Visuospatial Ability

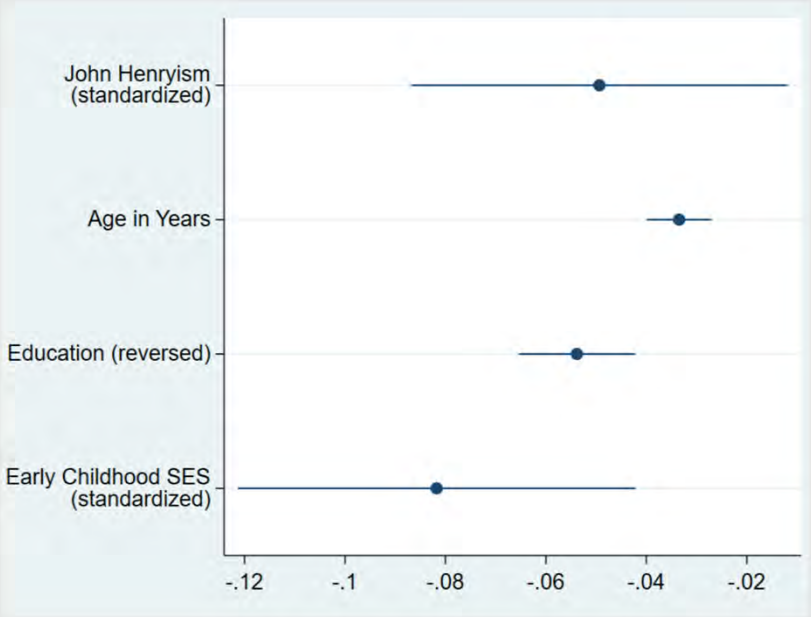
Turner, James, Capuano, et al., AJGP, 2017

46

46

John Henryism is associated with lower cognition

A strategy for coping with prolonged exposure to stressors, developed by Sherman James



McSorley et al., 2022

47

47

Outline

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- Challenges in understanding greater risk
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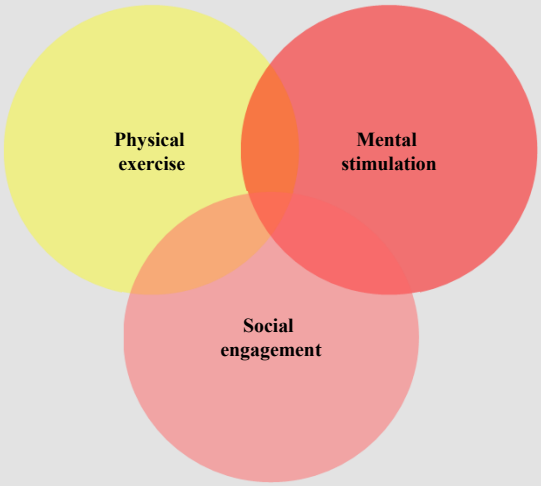
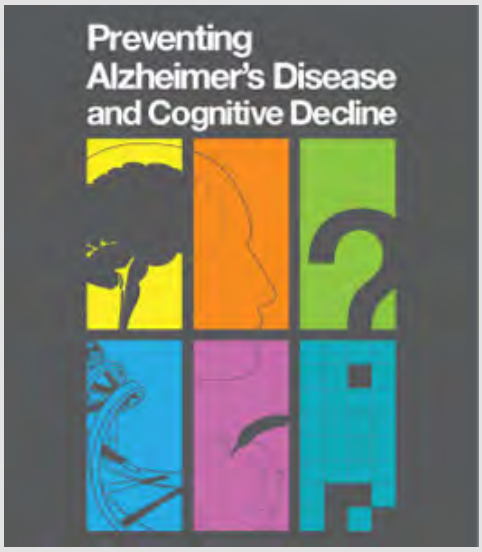
- Evaluate key prevention strategies to protect brain health in old age

48

48

Can Alzheimer's disease be prevented?





49

Potentially modifiable risk factors

Increase Risk

- Cerebrovascular disease (stroke)
- Diab[illegible]es
- H[illegible]nsio[illegible]
- Dis[illegible]ss
- Lone[illegible]
- Depre[illegible]mptoms
- Parl[illegible]ns
- C[illegible]eight loss)
- C[illegible]n
- Saturated/transunsaturated fats
- Current Smoker

Decrease Risk

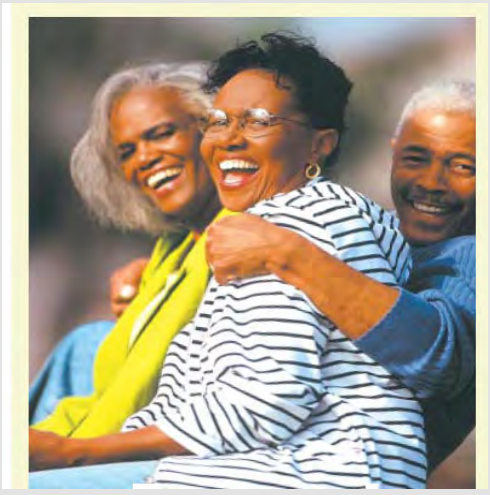
- **Occupation**
- **Cognitive activity**
- **Physical activity**
- **Social activity**
- **Social networks**
- **Omega 3-acids**
- **Folic acid intake**
- **Fruits and vegetables**
- **Mediterranean diet**
- **Moderate Alcohol intake**
- **Purpose in life**

50

More Frequent Cognitive Activity is GOOD!

51

Remain Socially Active



52

Remain Physically Active

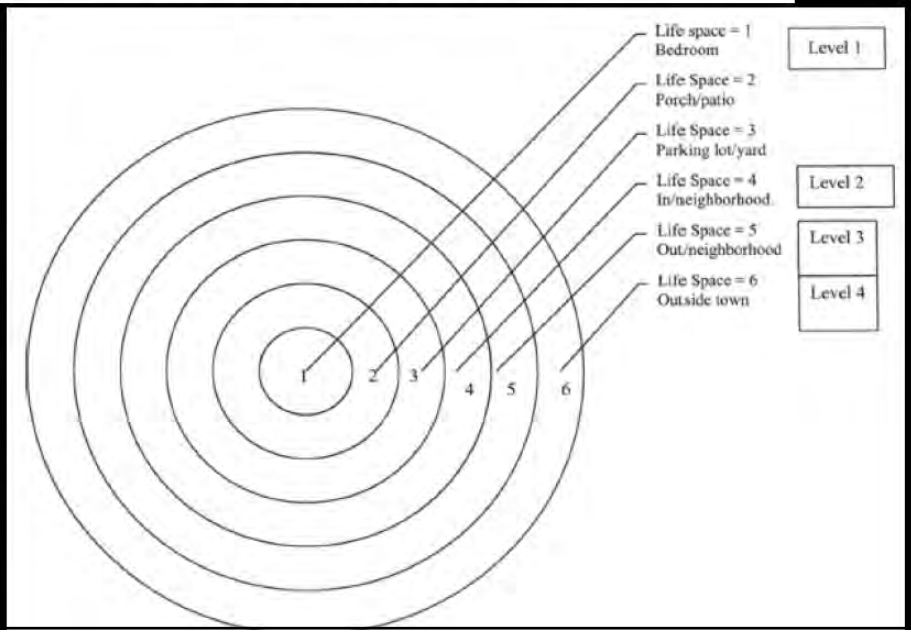
↓ Cardiovascular disease
Diabetes
Obesity
Hypertension
Some cancers
mortality

↑ Cognition

53

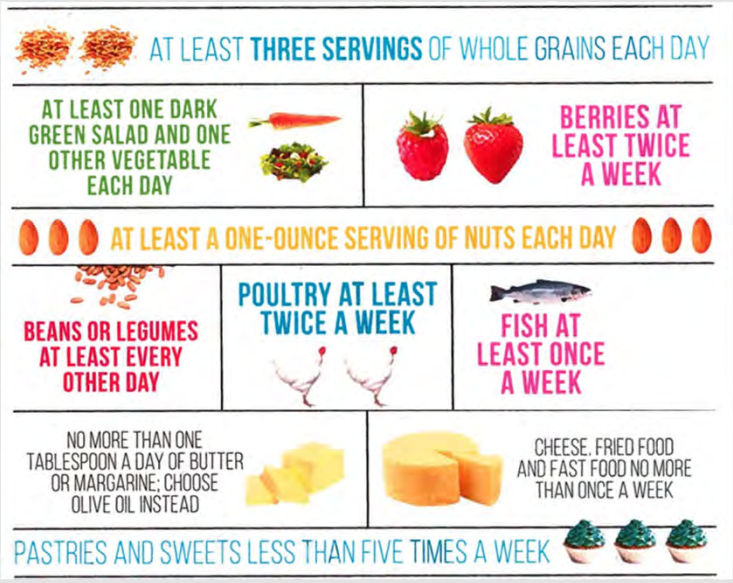
Life space and risk of Alzheimer's disease, mild cognitive impairment, and cognitive decline in older adults: prospective cohort study

Six zones in the past week



54

MIND DIET



Eat healthy foods!!

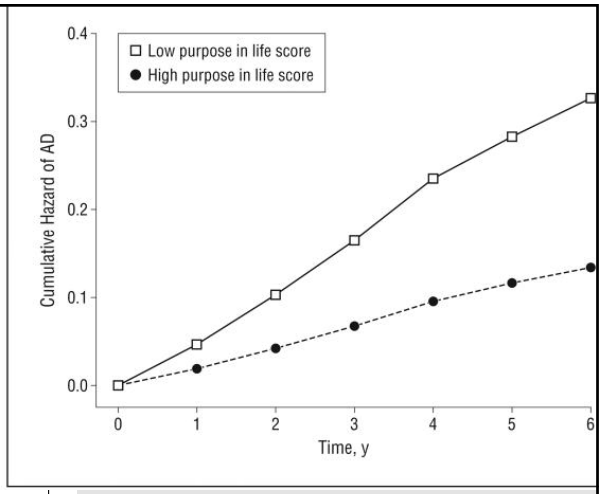
Green leafy vegetables, berries, whole grains, and fish associated with better cognition, lower Alzheimer's dementia risk, and less AD pathology in the brain

55

55

Higher purpose is protective!

	Statement
1	I feel good when I think of what I have done in the past and what I hope to do in the future.
2	I live life 1 day at a time and do not really think about the future.
3	I tend to focus on the present because the future nearly always brings me problems.
4	I have a sense of direction and purpose in life.
5	My daily activities often seem trivial and unimportant to me.
6	I used to set goals for myself, but that now seems like a waste of time.
7	I enjoy making plans for the future and working them to a reality.
8	I am an active person in carrying out the plans I set for myself.
9	Some people wander aimlessly through life, but I am not one of them.
10	I sometimes feel as if I have done all there is to do in life.



Boyle et al., 2010

56

56

Conclusions

- Some studies suggest African Americans have a higher risk of Alzheimer's disease
  - Racial differences in level of cognition but not in change over time
  - Suggests that racial differences in Alzheimer's dementia is due to racial differences in where people start (cognitive level)
- Longitudinal designs where people are followed over time are powerful tools to examine aging in diverse older adults
  - Controls bias associated with cross-sectional testing
- Context is important; lived experience of African Americans has an impact on cognition in later life
  - Studies that incorporate the life course and lived experience will advance the science of disparities and move us toward health equity

57

57

Conclusions con't

- Identification of risk factors for Alzheimer's disease and cognitive decline are important for prevention
- A number of psychosocial and experiential factors have been shown to be protective against Alzheimer's disease and cognitive decline
- Older adults should be encouraged to adopt these habits for brain health

58

58

Acknowledgments

National Institute on Aging
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Illinois Department of Public Health
Alla V. and Solomon Jesmer Chair

Study Participants :

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Rush Memory and Aging Project
Religious Orders Study
Chicago Health and Aging Project

59

59

Rush Alzheimer's Disease Center
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Zoe Arvanitakis, MD
Lisa Barnes, PhD
David Bennett, MD
Kate Blizinsky, PhD
Patricia Boyle, PhD
Aron Buchman, MD
Ana Capuano, PhD
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Jose Farfel, MD, PhD
Debra Fleischman, PhD
Crystal Glover, PhD
Fran Grodstein, ScD
Bryan James, PhD
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Brittney Lange-Maia, PhD
Katie Lopes, PhD
Sue Leurgans, PhD
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60

RADC Research Resource Sharing Hub

https://www.radc.rush.edu

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E gj~tzsl95

61

61

New Methods to Assess Financial Vulnerability, Exploitation and Wealth Loss in Older Adults

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New evidence-based tools can help identify who is at heightened risk for financial vulnerability and for wealth loss. This presentation will focus on the development and validation of these tools and how they can be put into your practice. A new model of financial capacity will also be presented and illustrated through case studies.

Financial Vulnerability, Exploitation and Wealth Loss and Cognitive Decline in Older Adults

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4

Conservatorship Assessment: Case Study

(Ms. AB)– A 75-year-old woman with a history of mental illness disability and repeated Mild TBI

5

Brief Background

- Referred by current Case Manager (RN)
- Prior to work with case manager, Ms. AB not tending to her medical problems (congenital hypothyroidism with history of severe mood swings)
- History of several concussions with brief LOC after being rear ended 4 years ago
- Neuropsych testing 10 years ago: Average IQ, some memory problems that improved on f/u testing one year later
- Not employed in 30 years due to emotional disability (likely both bipolar disorder and schizoaffective disorder)

6

Acute crisis

- When she suffered from COVID-19, her problem with hoarding intensified to the point that her apartment manager threatened her with eviction. The case was referred to Adult Protective Services. She was assigned a case manager through an Adult Protective Service worker intervening with the apartment manager.
- The case manager helped to get Ms. AB's thyroid condition and symptoms of bipolar disorder treated and under better control. Her symptoms of schizoaffective disorder continued, and the case manager reported that Ms. AB had significant difficulty with frustration tolerance and working constructively with others.
- RESULTED IN GUARDIANSHIP, BUT NO ACTION TAKEN WITH REGARD TO CONSERVATORSHIP AT THE TIME

7

Legal Issues

- Was on SSI for 26 years
- Sister died and left Trust with aunt as Trustee
- Was assigned a case manager
- Trust paid off $65,000 credit card debt
- Trust pays rent, medical and spending money of $2000/month
- After having COVID, APS was called due to self-neglect and hoarding (1 year prior to evaluation)
- Now Conservatorship has been filed by GA and being fought by Ms. M
- Court agreed for me to perform an IME

8

Issues to consider

- Still one minor TBI lawsuit outstanding—conduct effort testing
- Church "saved my life" and gave me purpose– all social contacts revolve around the church
- Use of Person-Centered Financial Management and Financial Decision-Making Assessment

9

Neuropsychology Test Highlights

- Used Warrington RMT for Faces for Effort testing (43/50)- WNL
- WASI- FSIQ 113, VIQ 117, PIQ 106
- Logical Memory I SS=2; LMII SS=3 (recalled material originally remembered)
- RAVLT: Delayed recall mildly impaired (SS=6) although trial 1 and LOT were unimpaired; Rey-Osterieth was unimpaired initially and on delay
- Trail making (practice effects?) WNL, Stroop WNL
- Arithmetic (WRAT-IV) Borderline

10

Assessing Financial Capacity

- **Step 1**: Confirmed regular income of $2,000 per month.
- **Step 2:** Reviewed checking account and credit card statements x 9 months and compared to what she was telling me. Very detailed check register and had all credit card statements. In past 9-months already had 3 new credit cards and $25,000 of new debt.
- **Step 3:** Individual purchases that stood out? None
- **Step 4:** Stress tests of categories of expenses. Reported 10% tithe to church, however amount was close to 30% of her $2000 monthly allotment. Excessive home shopping network amounts.
- **Step 5: Financial Decision Making:** LFDRS: admits to excessive spending, worry about debt, psychological vulnerability around money

Records do not help her compensate—they are overly complex and detailed with no reminders/plans for containing spending

11

Steps in Assessing Capacity

1. Neurocognitive or mental health impairment?

Ms. AB had a complex mental health disorder with diagnoses of both bipolar disorder and schizoaffective disorder. Superimposed on this was a series of Mild Traumatic Brain Injury experiences. The combination led to some executive functioning and emotion-regulation deficits. Overall, the cognitive deficits were mild, whereas the mental health disorder was at least in the moderate range.

12

Steps in Assessing Capacity

2. Specific financial management and informed financial decision-making abilities

Deficits were documented in both financial management and informed financial decision-making skills. MS. AB was overspending her monthly income and creating new and significant debt. She grossly underestimated her spending in certain categories. In terms of financial decision-making, Ms. AB demonstrated a lack of appreciation of financial risks (i.e., severe debt) and an understanding of how she spent her income. These were deficits in fundamental aspects of informed decision-making (see, Appelbaum & Grisso, 1988).

13

Steps in Assessing Capacity

3. Awareness of Deficit and Ability to Compensate

Ms. AB lacked any awareness of her financial management, decision-making, or neurocognitive deficits. In addition, she saw no need to utilize compensatory strategies and instead her solution was to pressure her Trustee to give her more money.

14

Steps in Assessing Capacity

4. Integration with Legal Standards

In Michigan, the legal standards for meeting the Conservatorship standard are twofold:

(1) the presence of a neurocognitive condition or mental health disorder that made the person unable to manage her finances and

(2) the waste of assets without proper oversight. Ms. AB's long-term mental health disorder, neurocognitive deficits, and lack of awareness and ability to compensate made her unable to properly manage her finances and her finances would be wasted without oversight.

It was recommended that she be assigned a Conservator.

15

Conclusion

Executive functioning deficits interfere with ability to manage finances.

Without oversight monies (already are) will be wasted or dissipated due to deficits in financial decision-making and financial management.

Inability to compensate for deficits

Conclusion: Ms. M *does* meet the legal standard for needing a Conservator

16

In Sum: The Domains of Financial Capacity

Being able to:

1. Avoid financial exploitation
2. Make informed financial decisions
3. Manage personal finances

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The Domains of Financial Capacity: Financial Management, Financial Decision Making and Avoiding Financial Exploitation

The WALLET Study: *Wealth Accumulations and Losses in Later Life Early Cognitive Transitions*

18

How many people have performed a financial capacity evaluation?

Poll Question #1

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In assessing financial capacity,

how many people have found evidence of suspected financial exploitation?

Poll Question #2

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Defining Financial Exploitation

Misappropriation or misuse of the funds of an older and/or vulnerable adult

Includes fraud, family or friend exploitation, exploitation by staff or professionals

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Financial Exploitation: What Is It?

Six Domains*

Theft & Scams
Has anyone misused your ATM or credit card?

Abuse of Trust
Has someone convinced you to turn the title of your home over to them?

Financial Entitlement
Has anyone felt entitled to use your money for themselves?

Coercion
Did anyone put pressure on you to get a reverse mortgage?

Signs of Possible Financial Exploitation
Has anyone been frequently asking you for money?

Money Management Difficulties

*Conrad et al. (2010)

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Brooke Astor, NYC Philanthropist and Socialite financially exploited by son

Brooke Astor had Alzheimer's Disease

23

Examples of How Domains of Financial Exploitation Reveal Themselves

- **Abuse of Trust:** Mr. D, a financial planner for an older woman whose only family (sister) lived in Poland. After woman moved to Assisted Living . . .
- **Financial Entitlement:** An 85-year-old man moved back home after a serious illness and medical rehabilitation . . . to find his home emptied out and his car sold by his son who had POA.
- **Coercion (Undue Influence):** A younger neighbor, despite being out of touch with the older man for over a decade, moves the older gentleman into his home after the gentleman suffered a severe TBI with a subdural hematoma which resulted in dementia . . .

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Financial Exploitation Focus Emerged in 2008

- **MetLife Study** – impact estimated at $2.9 billion per year, and 10% increase between 2008-2010.
- Study measured media coverage not incidence

Consumer Finance Protection Bureau (CFPB) Suspicious Activity Reports (SARs) 2019

- Reports from Financial Institutions: Deposit Institutions (Banks, Credit Unions) and Money Services Businesses (e.g., MoneyGram, Western Union)
- SAR reports quadrupled between 2013 (1300/month) and 2017 (5700/month)
- 2017 losses connected to SARs $1.7 Billion in 2017
- 80% SARs loss to an older adult; Mean loss $34,000; 7% $100K+
- 69% 60 yo+
- 56% 70 yo+
- 33% 80 yo+

Comparison of FE characteristics between Institutions

Money Services Businesses (MSB)
- 69% Stranger Scams
- Romance, Relative in Need, Lottery

Deposit Institutions (DI)
- 27% Stranger Scams
- 67% knew suspect

- Overall: 51% stranger; 36% known person (70% family; 19% fiduciary)
- Biggest losses—Fiduciary average loss $83,600

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What We Observed During the COVID-19 Pandemic

- APS began seeing increased cases of romance scams
- Banks/Credit Unions also saw increase in romance scams
- Older adults reported higher rates of being contacted by would-be financial exploiters

28

Loneliness and Psychological Vulnerability cause risk for scams

29

Lichtenberg et al. 2013 & 2016 Psychological Vulnerability

2013: The strongest finding, however, was the prevalence of fraud in persons with the highest depression and lowest social-needs fulfillment **(14%)** compared to the prevalence of fraud in the rest of the sample **(4.1%; X2= 20.49; p < .001)**

2016: Fraud prevalence among those with clinically significant depression and the lowest **10%** in social-needs fulfillment **(8.7%)** was more than twice as high compared to the rest of the sample **(4.1%; χ2 = 7.85, p = .005).**

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Financial Exploitation Prevalence

- **Acierno (2010)**: 5772 National Prevalence Sample 5% older adult victims of FE (not including scams) 2nd only to emotional abuse
- **Beach (2010)**: 10% older adult victim of FE since age 60 (including scams)
- **Burnes,** et al. 2017 meta-analysis -- 5% older adult victims of fraud each year
- **Predictors**: Psychological factors, financial factors, vulnerability factors

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Statistics from the Elder Fraud Report (2021) of the Federal Bureau of Investigations

2021 VICTIMS BY AGE GROUP

VICTIMS		
Age Range[2]	Total Count	Total Loss
Under 20	14,919	$101,435,178
20 - 29	69,390	$431,191,702
30 - 39	88,448	$937,386,500
40 - 49	89,184	$1,192,890,255
50 - 59	74,460	$1,261,591,978
Over 60	92,371	$1,685,017,829

32

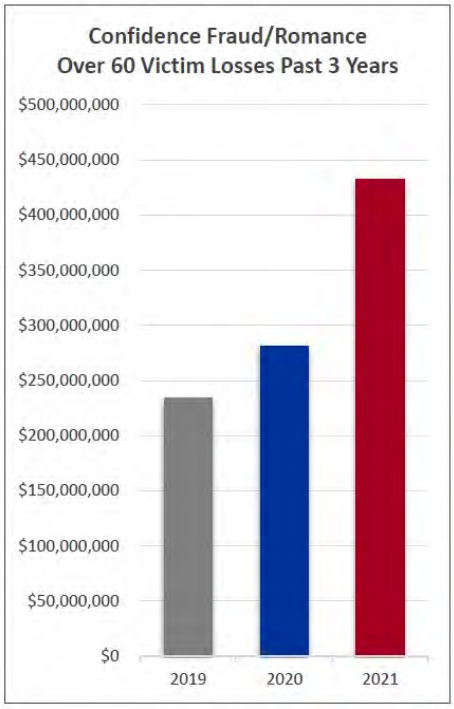
33

OVER 60 VICTIM REPORTING FOR PAST FIVE YEARS[3]

[2] Not all complaints include an associated age range—those without this information are excluded from this table. Please see Appendix B for more information regarding IC3 data.

[3] Charts describe Over 60 Victim Counts and Losses from 2017 – 2021.

34



35

Key Question in Elder Justice: Integrity of Financial Judgment

Both under and over-protection of older adults can lead to damaging consequences

- **Under protection** for older adults can lead to gross financial exploitation that can impact every aspect of the older adult's life.
- **Over protection** can be equally as costly. Many older adults have very strong needs for autonomy and control and to unnecessarily limit autonomy can lead to increased health problems and shortened longevity.

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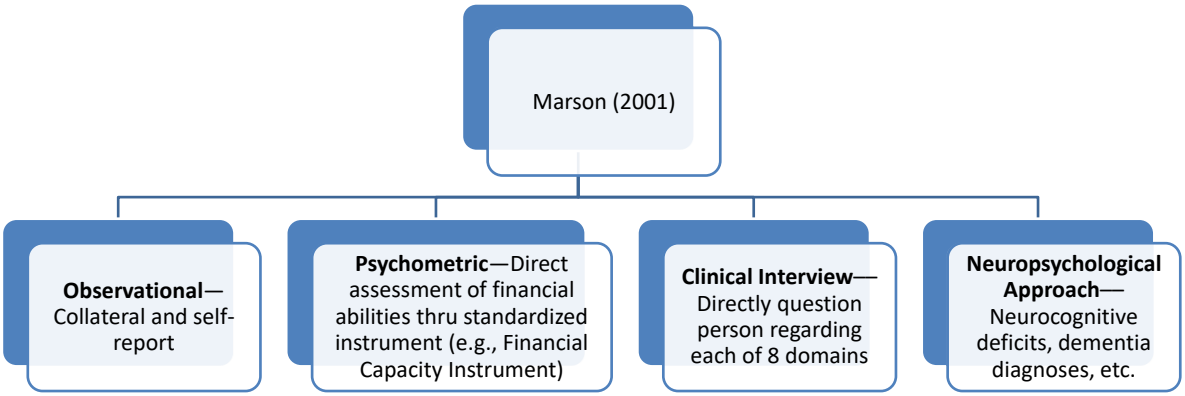
Traditional Approaches to Assessing Financial Capacity



37

Aging, Neuropsychology, and Cognition
2001, Vol. 8, No. 3, pp. 164–181

1382-5585/01/0803-164$16.00

Loss of Financial Competency in Dementia: Conceptual and Empirical Approaches

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Department of Neurology, Alzheimer's Disease Research Center, and Center for Aging, University of Alabama at Birmingham, AL, USA

38

New Approach to Conceptualization and Measurement of Financial Decision Making

The Lichtenberg Financial Decision Rating Scale (**LFDRS**)

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39

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A Person-Centered Approach to Financial Capacity Assessment: Preliminary Development of a New Rating Scale

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40

Using Person-centered Principles for Financial Decision-Making Capacity

- Mast (2011) Whole Person Dementia Assessment approach; integrates person-centered ideas with standardized assessment
- Context matters
- Voice of older adult is critical
- Real life decisions vs. vignettes

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41

Groundbreaking Work of Appelbaum & Grisso 1988

Originally for capacity for psychiatric treatment and guardianship, then health decisions

Identify Four Aspects of Decision Making that *Communicate*:

- Choice
- Appreciation
- Reasoning
- Understanding

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Differing Legal Standards for Capacity

- **Capacity to enter into a contract** (e.g. real estate)--Estate of Erickson 202 Mich APP 329, 331, 508 NW2d 181 (1993) indicates that person executing a real estate contract such as a home equity loan must possess sufficient mind to *understand,* in a reasonable manner the *nature and effect* of the act in which he is engaged.
- **Testamentary capacity in Michigan** requires (per MCLA 700.2501, 700.7601) the person making a will
  - Understand the purpose of the document;
  - Has the ability to know the nature and extent of his or her property;
  - Knows the natural objects of his of her bounty; and
  - Has the ability to understand in a reasonable manner the general nature and effect of his or her in signing the will (or trust per 700.7601).
- **Rationale/Reasoning**—implicit to these, but so important to consider

43

Expert Panelists

Using the Concept Mapping Model (Conrad et al., 2010), we then assembled two groups of experts:

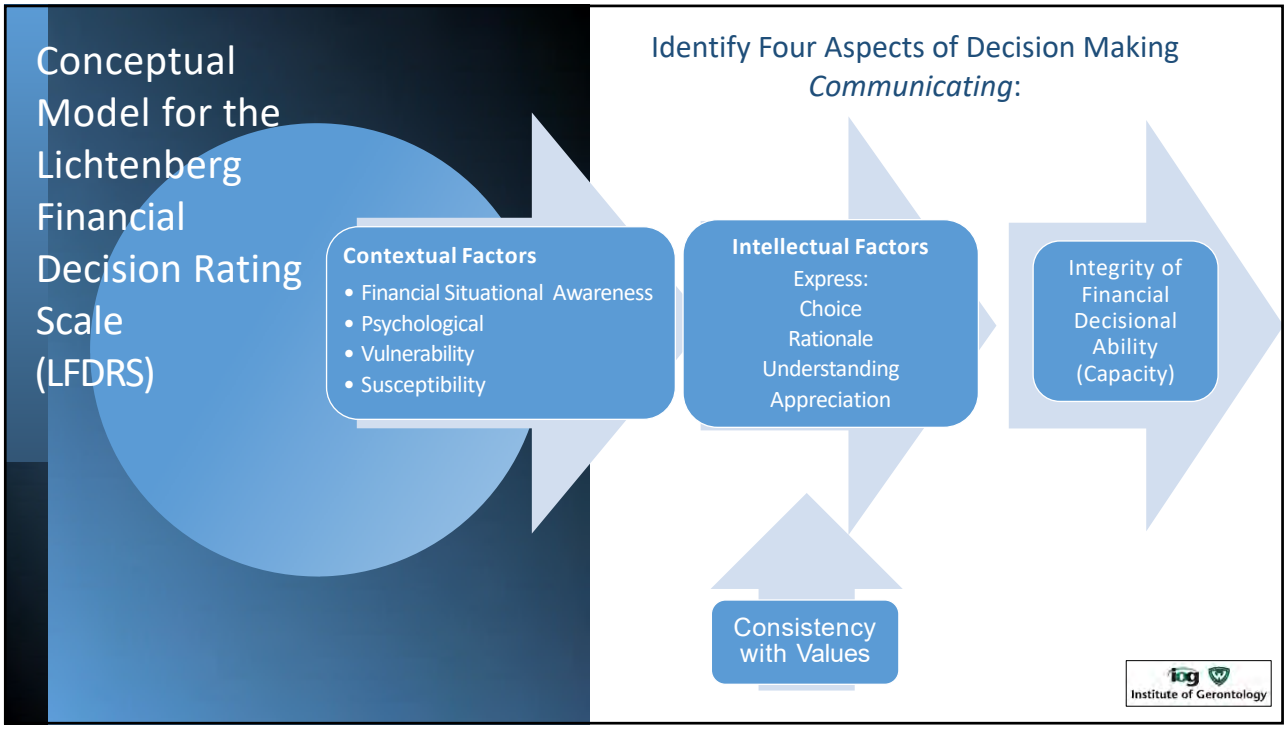
6 were engaged in financial-capacity work across the nation

14 were local and worked directly, on a daily basis with older adults making sentinel financial decisions and transactions

Create new conceptual model for FDM

Create final list of items for scale

44


Conceptual Model for the Lichtenberg Financial Decision Rating Scale (LFDRS)
Identify Four Aspects of Decision Making *Communicating*:
Contextual Factors
• Financial Situational Awareness
• Psychological
• Vulnerability
• Susceptibility
Intellectual Factors
Express:
Choice
Rationale
Understanding
Appreciation
Integrity of Financial Decisional Ability (Capacity)
Consistency with Values
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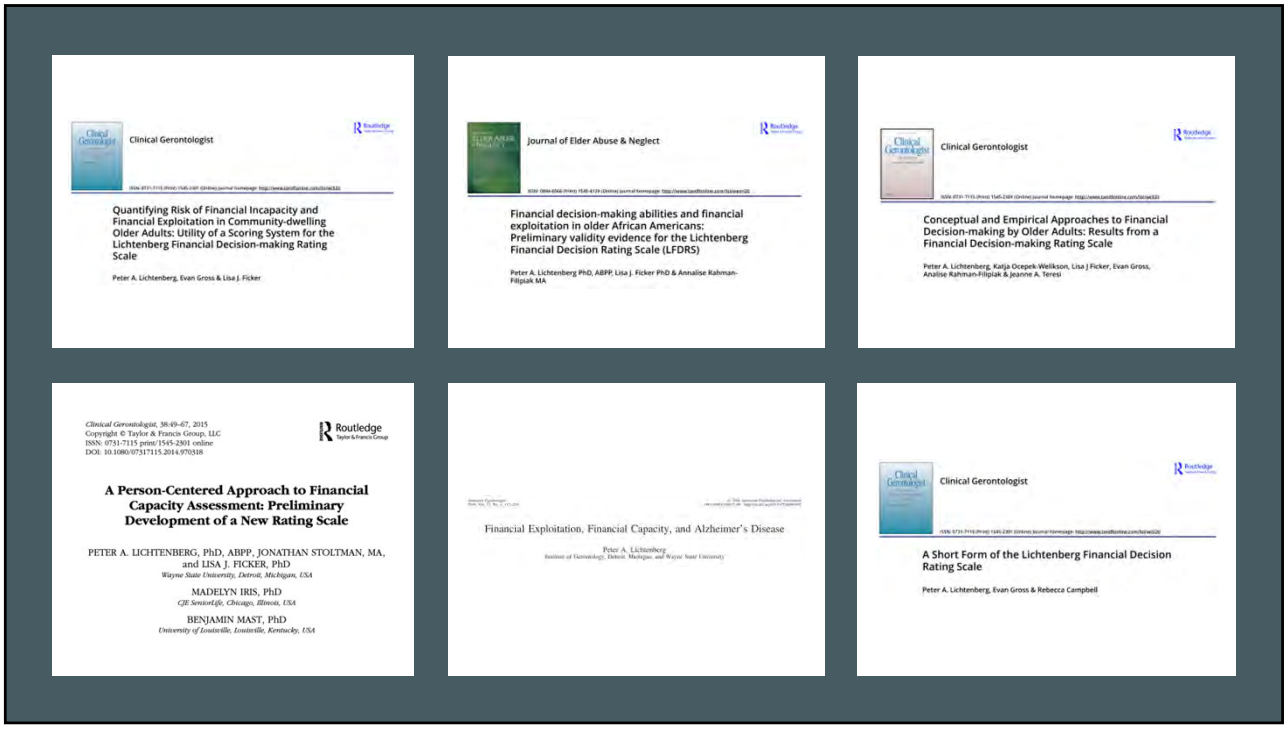
45


Clinical Gerontologist
Quantifying Risk of Financial Incapacity and Financial Exploitation in Community-dwelling Older Adults: Utility of a Scoring System for the Lichtenberg Financial Decision-making Rating Scale
Peter A. Lichtenberg, Evan Gross & Lisa J. Ficker
Journal of Elder Abuse & Neglect
Financial decision-making abilities and financial exploitation in older African Americans: Preliminary validity evidence for the Lichtenberg Financial Decision Rating Scale (LFDRS)
Peter A. Lichtenberg PhD, ABPP, Lisa J. Ficker PhD & Annalise Rahman-Filipiak MA
Clinical Gerontologist
Conceptual and Empirical Approaches to Financial Decision-making by Older Adults: Results from a Financial Decision-making Rating Scale
Peter A. Lichtenberg, Katja Ocepek-Welikson, Lisa J Ficker, Evan Gross, Analise Rahman-Filipiak & Jeanne A. Teresi
Routledge
A Person-Centered Approach to Financial Capacity Assessment: Preliminary Development of a New Rating Scale
PETER A. LICHTENBERG, PhD, ABPP, JONATHAN STOLTMAN, MA, and LISA J. FICKER, PhD
MADELYN IRIS, PhD
BENJAMIN MAST, PhD
Financial Exploitation, Financial Capacity, and Alzheimer's Disease
Peter A. Lichtenberg
Clinical Gerontologist
A Short Form of the Lichtenberg Financial Decision Rating Scale
Peter A. Lichtenberg, Evan Gross & Rebecca Campbell

46

Case Study: Romance Inheritance Scam

- 82-year-old divorced retiree — net worth $12M — mostly in properties
- Gets tangled in romance scams with "2 different women who want to marry him"
- Inheritance Twist: The women need to marry and go to Ireland to receive "their $15M estate" because "in their culture only married women can receive inheritance." Need attorney and other fees
- Sends several hundred thousand to "the attorneys"
- Drives 1000 miles to look for one of the "wives"
- I'm called in to do an evaluation

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47

Case Study cont.

- **Impact:** Failure to pay taxes—about to be foreclosed on, rotted food in fridge, not sleeping or eating, getting calls round the clock
- **Neurocognitive:** Exceptionally smart, high functioning with executive deficits and ***paranoia***.
- **Despite intervention by bank and FBI**, he still believes the women exist and this is a legit enterprise
- **States**: "I am worth several million so let me spend the money the way I want."

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48

LFDRS-SF (FVA) Highlights

Q4 What is your primary financial goal for this decision? *Lifestyle (no monetary goal; meet a need or desire)*

- Do you agree with the respondent's answer? *No*
- Please select what you feel the correct response to be *Earn money (or retain value of investment)*
- Please provide input on why you do not agree *He wants control of his money so that he can continue to pursue romance/inheritance*

Q5 How will this decision impact you now and over time?

- *Improve financial position*
- Do you agree with the respondent's answer? *No*
- Please select what you feel the correct response to be *Negative impact/debt*
- Please provide input on why you do not agree *Already a history of losing money*

Q6 How much risk is there to your financial well-being? *Low risk or none*

- Do you agree with the respondent's answer? *No*
- Please select what you feel the correct response to be *High risk*

-continued-

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LFDRS-SF (FVA) Highlights cont.

Q18 How often do your monthly expenses exceed your regular monthly income? *Some of the time*

- Notes: *Last several months during the scam*

Q26 How worried are you that someone will take away your financial freedom? *Very worried*

Q28 As you have grown older, has a relationship with a family member or friend become strained due to finances? *Yes*

- **Q28** If YES, how strained?

You terminated contact with this person due to problems

Q34 How likely is it that someone now wants to take or use your money without your permission? *Very likely*

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Utah Code 75-1-201

Guardianship: Incapacity is demonstrated by an adult's failure to

- receive and evaluate information
- make and communicate decisions
- provide for necessities such as food, shelter, clothing or safety

The code further states that even with appropriate technical assistance the individual lacks the ability to meet essential requirements for financial protection.

Utah Code 75-5-303 Limited Guardian (this is preferred whenever possible)
Utah Code 75-5-401 Conservator is necessary when an individual is unable to manage his or her property.

51

Summary and Conclusions

My evaluation of Mr. R revealed:

- His cognitive assessment, combined with his history of physical and behavioral decline are consistent with a diagnosis of **Major Neurocognitive Impairment** in the Mild Stage. The etiology of these deficits is likely vascular in nature.
- His cognitive deficits are directly related to his **vulnerability to scams**. His lack of mental flexibility, over-confidence and failure to be aware of patterns of deceit are entirely consistent with his cognitive deficits in abstract thinking and mental flexibility.
- Mr. R has a strong desire for personal control and his lack of social outlets leaves him wanting to be a person of great significance in the life of another (e.g. scammers). The **need for status and confirmation** are important social needs largely unfulfilled in Mr. R's life.
- Mr. R has developed a **strong paranoia** toward four of his adult children. He said that, without first talking with him about the scams, the family simply went to court to take away his rights. The strength of this belief is more than a disagreement, and not in agreement with the facts.
- Mr. R is an individual who **meets the legal standards for incapacity** by virtue of his inability to receive and evaluate information. He demonstrated decisional ability deficits with regard to understanding and appreciation.

52

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Quantifying Risk of Financial Incapacity and Financial Exploitation in Community-dwelling Older Adults: Utility of a Scoring System for the Lichtenberg Financial Decision-making Rating Scale

Peter A. Lichtenberg, Evan Gross & Lisa J. Ficker

53

Table 4. Descriptive statistics of demographics and LFDRS Total and Subscale Scores by suspected history of financial exploitation.

Variable	Total (N = 200) *M* (*SD*) or %	No SFE (n = 164) *M* (*SD*) or %	SFE (n = 36) *M* (*SD*) or %	*p*-value*
Age	71.5 (7.4)	71.5 (7.4)	71.3 (7.4)	.868
Education (years)	15.3 (2.6)	15.5 (2.6)	14.9 (2.5)	.223
Race				.115
Caucasian	48.0%	50.6%	36.1%	
African American	52.0%	49.4%	63.9%	
Gender (female)	74.0%	71.3%	86.1%	.067
LFDRS Total	16.0 (8.6)	14.2 (6.8)	24.4 (10.8)	<.001
FSA	7.2 (3.2)	6.8 (3.1)	8.9 (3.2)	<.001
PV	3.1 (2.8)	2.7 (2.5)	4.7 (3.4)	<.001
Susceptibility	3.6 (3.8)	2.7 (2.7)	7.2 (5.5)	<.001
Intellectual	2.3 (2.0)	1.96 (1.6)	3.5 (3.0)	.004

Note: SFE = Suspected financial exploitation; LFDRS = Lichtenberg Financial Decision Rating Scale; FSA = Financial Situational Awareness; PV = Psychological Vulnerability.
*p-values are reported for t-tests or chi-square tests as appropriate.

54

Table 7. Results of chi-square test and descriptive statistics for cognitive status by SFE.

Cognitive Status	No SFE	SFE
WNL	138 (85.7%)	24 (14.3%)
PCD	26 (68.4%)	12 (31.6%)

Note: $\chi^2 = 5.86$, df = 1, $p = .015$. Numbers in parentheses indicate row percentages.

55

Promoting Autonomy in Financial Decision Making in People with Cognitive Impairment

- 84-year-old man suffered injury and in rehab
  He wants to change POA
- 82-year-old woman misdiagnosed with AD and wants to fight conservatorship
- 87-year-old man with MCI challenges conservatorship and guardianship application
- 90-year-old man with mild stage dementia. He makes a change to his will to benefit his only daughter

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56

Informed Financial Decision-Making Assessment Tools

Formed 3 New Scales:

Lichtenberg Financial Decision Screening Scale (LFDSS) aka FDT
Lichtenberg Financial Decision-Making Rating Scale (LFDRS) aka FVA
LFDRS-I Family/Friends Informant Scale FFI

https://olderadultnestegg.com
FDT, FVA, FFI

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Why Evidence-based Tools Are Important

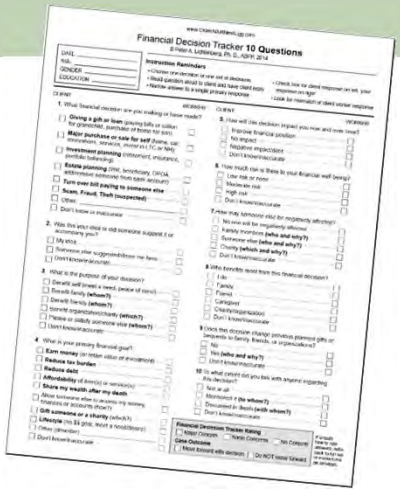
Reliable

Replicable

Efficient

58

Lichtenberg Financial Decision Screening Scale (LFDSS)



AKA –
"Financial Decision Tracker"(FDT)

Foundational to the Rating Scale

https://www.OlderAdultNestEgg.com

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59

Lichtenberg Financial Decision Screening Scale (**LFDSS**)

- 10 items: Administered in an interview format
- Multiple choice
- Focuses on the 4 intellectual factors and potential for undue influence
- Professional does the rating on each item and does not just record older adult's responses
- Overall judgment score based in part on don't know or inaccurate responses

60

10 Questions from LFDSS

1. What is the financial decision you are making? **Choice**
2. Was this your idea or did someone suggest it or accompany you? **Autonomy**
3. What is the purpose of your decision? **Rationale**
4. What is the primary financial goal? **Understanding**
5. How will this decision impact you now and over time? **Understanding**
6. How much risk is involved? **Appreciation**
7. How may someone else be negatively affected? **Appreciation**
8. Who benefits most from this financial decision? **Understanding**
9. Does this decision change previous planned gifts or bequests to family, friends, or organizations? **Appreciation**
10. To what extent did you talk with anyone regarding this decision? **Autonomy**

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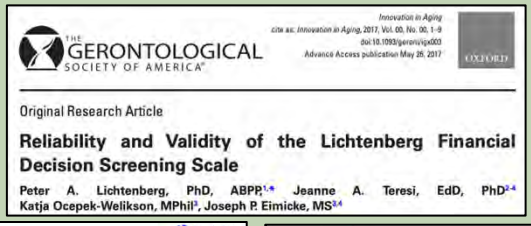
61



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62

LFDSS Questions 1-3

1. What financial decision are you making or have made?
- ◯ a. Giving a gift or loan (pay bills/tuition for grandchild, purchase home for child)
- ◯ b. Major purchase or sale (home, car, renovations, services)
- ◯ c. Investment planning (retirement, insurance, portfolio balancing)
- ◯ d. Estate planning (Will, beneficiary, add/remove someone from bank account)
- ◯ e. Turn over bill paying to someone else
- ◯ f. Scam, fraud, theft (suspected)
- ◯ g. Other (describe) _____
- ◯ h. Don't know

2. Was this your idea or did someone else suggest it or accompany you?
- ◯ a. Your idea
- ◯ b. Someone suggested/accompanied you (who?) _____
- ◯ c. Don't know

3. What is the primary purpose of your decision for your?
- ◯ a. Benefit you (meet a need, peace of mind)
- ◯ b. Benefit family (who?) _____
- ◯ c. Benefit friends (who?) _____
- ◯ d. Benefit organization/charity (which?) _____
- ◯ e. Please or satisfy someone else (who?) _____
- ◯ f. Don't know

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63

LFDSS Questions 4-6

4. What is your primary financial goal for this decision?
- ◯ a. Earn money (or retain value of investment)
- ◯ b. Reduce tax burden
- ◯ c. Reduce debt
- ◯ d. Affordability of item(s) or service(s)
- ◯ e. Share wealth after your death
- ◯ f. Allow someone else to access your money, finances or accounts (how?) _____
- ◯ g. Gift someone or a charity (which?) _____
- ◯ h. Lifestyle (no monetary goal; meet a need/desire)
- ◯ i. Other (describe) _____
- ◯ j. Don't know

5. How will this decision impact you now and over time?
- ◯ a. Improve financial position
- ◯ b. No impact
- ◯ c. Negative impact/debt
- ◯ d. Don't know

6. How much risk is there to your financial well-being?
- ◯ a. Low risk or none
- ◯ b. Moderate risk
- ◯ c. High risk
- ◯ d. Don't know

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64

LFDSS Questions 7-10

7. How might someone else be negatively affected?
- ◯ a. No one will be negatively affected
- ◯ b. Family member(s) (who & why?) _____
- ◯ c. Someone else (who & why?) _____
- ◯ d. Charity (which & why?) _____
- ◯ e. Don't know

8. Who benefits most from this financial decision?
- ◯ a. You do
- ◯ b. Family (who?) _____
- ◯ c. Friend (who?) _____
- ◯ d. Caregiver (who?) _____
- ◯ e. Charity/organization (which?) _____
- ◯ f. Don't know

9. Does this decision change previous planned gifts or bequests to family, friends, or organizations?
- ◯ a. No
- ◯ b. Yes (who & why?) _____
- ◯ c. Don't know

10. To what extent did you talk with anyone regarding this decision?
- ◯ a. Not at all
- ◯ b. Mentioned it (to who?) _____
- ◯ c. Discussed in depth (with who?) _____
- ◯ d. Don't know

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65

Case Example

A 68-year-old high school graduate is considering buying a new home for her grandson.

- She has relatively few resources herself and this purchase would put her at risk for financial hardship
- She will lack access to the cash she will spend and will be responsible for the mortgage payments
- She would be financially responsible should her grandson decide to no longer pay the monthly bills.
- Grandson is marginally employed and has no financial resources; making an investment in him a significant risk.

66

Case Example

Romance Scam

Q1

What financial decision are you making or have made? (CHOICE)
Don't know or inaccurate response

Do you agree with the respondent's answer? *No*

Please select what you feel the correct response to be: *Scam, fraud, theft (suspected)*

Please provide input on why you do not agree. *Client is currently being heavily influenced by a much younger female.*

Q2

Was this your idea or did someone else suggest it or accompany you? *Someone else*
Suggested/accompanied you (who?) - *Sons*

Q3

What is the primary purpose of this decision? *Please or satisfy someone else*
(Who?) - *Prove that everyone is wrong*

Do you agree with the respondent's answer? *Yes*

Q4

What is your primary financial goal for this decision? *Lifestyle (no monetary goal; meet a need or desire)*

Do you agree with the respondent's answer? *Yes*

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67

Romance Scam cont.

Q5

How will this decision impact you now and over time? (UNDERSTANDING) *No impact*

Do you agree with the respondent's answer? *No*

Please select what you feel the correct response to be. *Negative impact/debt*

Please provide input on why you do not agree. *Financially restricting and overall detrimental to health*

Q6

How much risk is there to your financial well-being?

(APPRECIATION) *Low risk or none*

Do you agree with the respondent's answer? *No*

Please select what you feel the correct response to be. *Moderate risk*

Please provide input on why you do not agree. *Spending over double the amount per month than he had been prior to becoming involved with this female.*

Q7

How might someone else be negatively affected? *No one will be negatively affected*

Do you agree with the respondent's answer? *Yes*

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68

Wtr fshj%Xhfr %htsy3

Q8
Who benefits most from this financial decision? (UNDERSTANDING) *You do*

Do you agree with the respondent's answer? *No*

Please select what you feel the correct response to be. *Friend* **(Who?)**

Please provide input on why you do not agree. *Female acquaintance*

Q9
Does this decision change previous planned gifts or bequests to family, friends or organizations? *No*

Do you agree with the respondent's answer? *Yes*

Q10a
To what extent did you talk with anyone regarding this decision? *Not at all*

Do you agree with the respondent's answer? *Yes*

RISK SCORE = 11 / Above Cutoff
Major Concerns—evidence for deficits in informed decision making

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69

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Special Issue: Implementation Science in Gerontology: Research Article

Implementing a Financial Decision-Making Scale in APS Financial Exploitation Investigations: Use of the PARIHS Conceptual Framework

Peter A. Lichtenberg, PhD, ABPP,[1,2,*] Joshua Mandarino, MA,[3] Lisa Fisher, MSW,[3] Maggie Tocco, LCSW, MSW,[1] Juno Moray, MA,[1] and Marie Shipp, MA[3]

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70

Implementation Science

- Implementation science examines the translation of evidence-based practices into widespread usage.
- To do so, it uses scientific conceptual models and methods to discern processes that are not typically governed by rationality.
- If the adoption of evidence-based practices were straightforward and rational, it would consist of adopting passive methods to disseminate evidence-based practices

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71

Implementation Science Approach

Used for Conceptual Framework: Promoting Action in Research Implementation in the Health Sciences (PARIHS), Kitson (1998)

Basic Elements

1. Evidence—research quality and support
2. Context– environmental factors that support implementation or not
3. Facilitation– how is implementation facilitated and by whom?
4. Website https://olderadultnestegg.com was key to widespread implementation

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72

Trial
APS Statewide Implementation

- **Goal:** Use our online training and scoring system to have all Michigan APS workers trained and certified and using the scale
- **Strategy:** Provide in-person or webinar training to all APS center supervisors to train and certify them first; then give similar training to field staff and have them trained and certified.
- Improvements to the system post-training allowed me to review each scale that was administered. Sent inquires to staff and supervisor for cases that had questions.

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73

Four major elements related to context were identified

Michigan APS is divided into five geographic sectors. The Continuity of all APS sector supervisors and their support Provided fertile ground for implementation.

Within the first year of the implementation trial, an APS liaison was assigned to expand the implementation of the FDT.

Access to the Older Adult Nest Egg website for training and certification, calculating risk scores, and receiving recommendations enabled statewide implementation.

Audit of Michigan APS completed prior to the creation of the FDT indicated a lack of risk-scoring tools' use in cases, and especially financial exploitation.

CONTEXT

74

Eight major facilitation elements emerged

1) The first author traveled to each APS sector to provide two trainings
2) The first author was able to review cases on the olderadultnestegg.com system and requested clarification via e-mail with the APS worker and supervisor for cases in which the tool may not have been properly administered.
3) The strong commitment of sector supervisors demonstrated their support for use of the tool for all APS staff.
4) A large feedback session organized by the APS liaison led to improved processes for APS workers.
5) The electronic record used by APS had a specific FDT results section for financial exploitation cases.
6) The FDT training and certification process was integrated into the onboarding process for new APS workers
7) The first author provided refresher trainings to APS sectors
8) APS case studies and feedback were integrated into trainings and widely disseminated. In a few cases, the use of the FDT was associated with saving an older adult as much as $2 million.

FACILITATION

75

Types of Decisions Made by Older Adults in Adult Protective Services Cases for Financial Exploitation

Table 1. Types of Decisions Made by Older Adults in Adult Protective Services Cases for Financial Exploitation

		Interviewer score		
	Overall sample	No concerns	Concerns	
	(N = 839)	(n = 468)	(n = 372)	
Decision type	n	n	n	Chi-square
A. Giving a gift	226 (26.94%)	133 (58.8%)	93 (41.2)	$\chi^2(1) = 9.36, p = .002$
B. Making a purchase	65 (7.75%)	43 (66.1%)	22 (33.9%)	$\chi^2(1) = 5.55, p = .018$
C. Participating in a scam	189 (22.53%)	62 (32.8%)	127 (67.2%)	$\chi^2(1) = 23.75, p < .001$
D. Allowing someone else access to your money	60 (7.15%)	33 (55.0%)	27 (45.0%)	$\chi^2(1) = 1.67, p = .197$
E. Allowing someone else to take over your finances	299 (35.64%)	197 (65.8%)	102 (34.2%)	$\chi^2(1) = 20.87, p < .001$

Note: Data collected from April 12, 2019 to December 31, 2021.
*$p < .05$; **$p < .01$.

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76

Interviewer Agreement with Risk Score for Overall Sample (N=839)

Table 2. Interviewer Agreement With Risk Score for Overall Sample ($N = 839$)

	Interviewer agreed with FDT risk rating	Interviewer disagreed with FDT risk rating	Interviewer reduced risk rating compared with FDT risk recommendation	Interviewer increased risk rating compared with FDT risk recommendation
	n	*n*	*n*	*n*
Cases	773 (92.13%)	66 (7.87%)	31 (3.69%)	35 (4.17%)

Note: FDT = Financial Decision Tracker.

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77

Table 3. Group comparison of scored FDT items based on interviewer's concern.

	No Concern (n = 223)	Some/Major Concern (n = 222)	Overall Sample (n = 445)	Group Comparison	Cohen's D
Was this your idea or did someone suggest it or accompany you?	0.48 (0.66)	0.93 (077)	0.71 (0.75)	$t(443) = -6.69$, $p < .001$	−0.634
How will this decision impact you now and overtime?	1.34 (0.99)	1.96 (0.92)	1.65 (1.00)	$t(443) = -6.88$, $p < .001$	−0.653
How much risk is there to your financial well-being?	0.72 (1.14)	1.61 (1.21)	1.16 (1.25)	$t(443) = -7.98$, $p < .001$	−0.757
How might someone else be negatively affected?	0.45 (0.73)	0.78 (0.84)	0.62 (0.80)	$t(443) = -4.49$, $p < .001$	−0.426
Who benefits most from this financial decision?	0.61 (0.73)	1.10 (0.75)	0.85 (0.78)	$t(443) = -6.92$, $p < .001$	−0.656
Does this decision change previous planned gifts or bequests to family, friends, or organizations?	0.24 (0.59)	0.46 (0.77)	0.35 (0.69)	$t(443) = -3.35$, $p < .001$	−0.318
To what extent did you talk with anyone regarding this decision?	0.07 (0.26)	0.12 (0.33)	0.10 (0.30)	$t(443) = -1.78$, $p = .075$	−0.169

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78

Routledge
Taylor & Francis Group

Journal of Elder Abuse & Neglect

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Assessment of financial decision making: an informant scale

Rebecca C. Campbell, Peter A. Lichtenberg, Latoya N. Hall, Jeanne A. Teresi & Katja Ocepek-Welikson

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79

Question Stems for the Family & Friends Interview

1. To your knowledge, what type of financial decision or transaction did your relative or friend recently make or is thinking of making?
2. Was this decision their idea or did someone else suggest it?
3. Now and over time, how do you think this decision or transaction will impact your relative or friend financially?
4. How much risk is there that this decision could result in a negative impact, such as loss of funds?
5. Overall, how satisfied is your relative or friend with finances?
6. Who manages your relative's or friend's money day to day?
7. Is your relative or friend helping anyone financially on a regular basis?
8. How often does your relative or friend seem anxious or distressed about financial decisions?

9A. Is your relative's or friend's memory, thinking skills, or ability to reason with regard to finances worse than a year ago?

9B. Has this interfered with their everyday financial activities?

10. Does your relative or friend regret or worry about a financial decision or transaction they made or intend to make?
11. Would others, who know your relative or friend well, say the current major financial decision is unusual for them?
12. To your knowledge, how much has your relative or friend come to rely on just one person for all financial decisions?
13. Has anyone used or taken your relative's or friend's money without their permission?
14. How likely is it that anyone now wants to take or use your relative's or friend's money without their permission?

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80

Older Adults and Financial Exploitation

SAFE

Successful Aging thru Financial Empowerment

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81

Older Adults as Targets

- Regular income
- Accumulated assets
- Sometimes have reduced financial management abilities
- May suffer issues with cognitive health
- Unlikely to report being victimized
- May have lower levels of social support

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82

The Effects of Financial Exploitation

- Loss of trust in others
- Loss of security
- Negatively impacts the physical, cognitive, and mental health of older adults
- Feelings of fear, shame, guilt, anger, self-doubt, remorse, worthlessness
- Financial destitution
- Inability to replace lost assets through employment
- Becoming reliant on government 'safety net' programs
- Inability to provide long term care needs
- Loss of primary residence

83

Financial Exploitation by Trusted Others

- 60% of financial exploitation perpetrators are family members. (Choi et al., 1999)
- Siblings and adult children have been recognized as perpetrators most often. (Lauman et al., 2008)
- Those victimized by family members on average have four times as much money stolen from them. (Gunther, 2011)
- 87.5% of financial abuse by family, friends, or acquaintances was not reported versus 33% of that perpetrated by strangers. (Arcierno et al., 2020)

84

Ten Most Costly Scams for Older Adults

(AARP, 2020)

1. Romance Scams ***$83.7 million***
2. Impostor: Government: ***$61 million***
3. Prizes, Sweepstakes and Lotteries: ***$51.4 million***
4. Impostor: Business ***$34.3 million***
5. Investments ***$25.4 million***
6. Computer Tech Support Scams ***$24.1 million***
7. Timeshare Sales ***$17.4 million***
8. Impostor: Family/Friends ***$17.1 million***
9. Online Shopping ***$14.2 million***
10. Timeshare Resales ***$12.5 million***

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85

RED FLAGS

PRESSURE (MNEMONIC)

Phone or other unsolicited contact by mail, email or text to start the scam. Phone calls are the most common.

Requesting you send money by gift card or wire transfer.

Extracting personal information from you, such as Social Security numbers or bank account numbers under the guise of needing to verify your identity.

Secrecy: Scammers insist you keep your contact with them a secret.

Spamming: Multiple emails or texts until one works on you.

Urgency: Scammers want you to act quickly before you start to become suspicious

Repetitive requests to provide money or information.

Emotional: Scammers appeal to emotions to make you panic (“Your grandson is in jail!”) or excited ("You won the grand prize!”) and act without thinking.

86

What We Do

Help	Educate	Support
Help older adults recover financially and emotionally after being victimized by financial scams or identity theft.	Educate older adults, and the people who care for them, about scamming and identity theft techniques, identification, protection and reporting.	Offer one-on-one support and education to caregivers on financial management issues

NO COST
Phone and Virtual Coaching/Advocacy sessions

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87

How We Help Older Adults

We can help with

- Filing police and consumer reports
- Contacting credit report agencies
- Disputing information on your credit report
- Contacting creditors and closing accounts
- Placing fraud alerts on your credit report
- And more...

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88

No Cost

SAFE Coaching Services

Zoom and/or phone Coaching/Advocacy Services for Older Adults

Contact
LaToya Hall, MSW
313-664-2608
L.hall@wayne.edu

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89

SAFE Identity Theft Case

- 63-year-old woman
- Turned down for auto loan by her bank
- Was referred to SAFE by bank staff to look over her credit and investigate the drop in her credit score.
- Uncovered many fraudulent accounts totaling approximately $5000 in debt.
- Worked with client to contact creditors, complete police reports, complete fraud affidavits, completing creditors fraud resolution process, placed fraud alert on credit report.

Saved $5000 through resolving fraudulent debt

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90

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OXFORD

Research Article

Context Matters: Financial, Psychological, and Relationship Insecurity Around Personal Finance Is Associated With Financial Exploitation

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Context Matters

- Examined 34 contextual items from the LFDRS
- Financial, psychological and relationship strain and insecurity differentiated FE (n=78) from non FE (n=168) group
- 17 items with Chronbach alpha .82, AUC .80 provided initial construct validity for a new self-report survey: Financial Exploitation Vulnerability Scale (FEVS)

On OlderAdultNestEgg.com
FEVS is referred to as the Financial Vulnerability Survey (FVS)

Initial Study Sample Characteristics

Table 1. Sample Demographics and Neuropsychological Testing

	No financial exploitation (n = 164)	Financial exploitation (n = 78)	Overall sample (n = 242)	
Age				
Years *M* (*SD*)	71.5 (7.4)	70.0 (7.8)	71.1 (7.6)	$t(236) = 1.39, p = .167$
Education				
Years *M* (*SD*)	15.4 (2.6)	14.2 (2.3)	15.1 (2.6)	$t(235) = 3.35^{**}$
Gender				
Female *N* (%)	117 (71.3%)	59 (74.7%)	176 (72.4%)	$\chi^2(1) = 1.86, p = .172$
Race				
Black *N* (%)	81 (49.4%)	51 (64.6%)	132 (54.3%)	$\chi^2(1) = 7.87^{*}$
WRAT-Word Reading				
Raw score *M* (*SD*)	58.0 (7.5)	54.8 (10.6)	57.0 (8.7)	$t(240) = 2.67^{*}$
MMSE				
Raw score *M* (*SD*)	28.7 (1.9)	27.6 (2.6)	28.3 (2.2)	$t(240) = 3.44^{**}$
TMT-B				
Seconds *M* (*SD*)	100.0 (46.2)	153.9 (76.3)	117.4 (62.8)	$t(234) = -6.71^{**}$

Note: MMSE = Mini-Mental Status Exam; TMT-B = Trail-Making Test Part B.
$^{*}p < .05$; $^{**}p < .001$.

93

ROC Curve – Initial Study

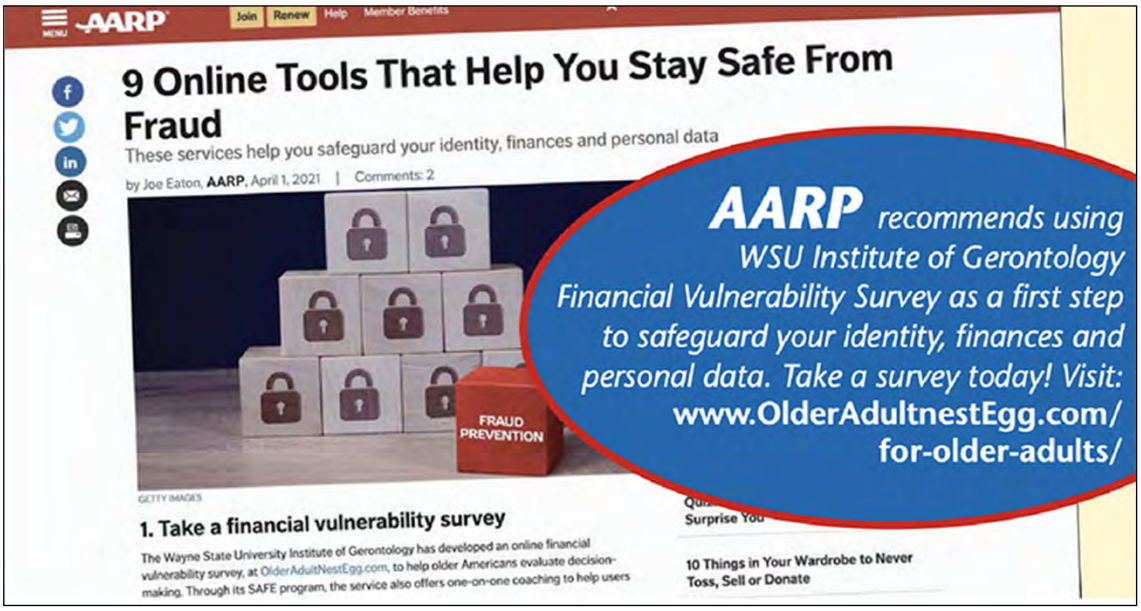
- AUC = 0.83
- Cron Alpha = 0.82

Table 5. FEVS Sensitivity, Specificity, and Negative and Positive Predictive Power for Each Cutoff Score

Cutoff	Sensitivity	Specificity	PPP	NPP
1 or greater	0.987	0.177	0.361	0.967
2 or greater	0.974	0.329	0.406	0.964
3 or greater	0.908	0.445	0.435	0.911
4 or greater	0.868	0.518	0.459	0.893
5 or greater	0.842	0.616	0.508	0.892
6 or greater	0.803	0.683	0.544	0.880
7 or greater	0.737	0.756	0.587	0.859
8 or greater	0.658	0.823	0.636	0.836
9 or greater	0.553	0.866	0.660	0.805
10 or greater	0.500	0.896	0.693	0.792
11 or greater	0.395	0.927	0.718	0.765

Note: NPP = negative predictive power; PPP = positive predictive power.

94



95

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Financial Vulnerability Survey

Date _____

Age:_____ Gender: Male Female

Highest Level of Education _____

Race/Ethicity _____

Survey results will be sent to the person who asked you to complete it. Please enter that name or their organization here:

Do you live alone? YES NO Are you employed? YES NO

Are you: Married__Life Partner (unmarried)____Widowed____ Single__

Secure ID Code: _____

_____

Instructions: Circle one answer per question

1) How worried are you about having enough money to pay for things?
   a. Not at all worried (0)
   b. Somewhat worried (1)
   c. Very worried (2)

2) Overall, how satisfied are you with your finances?
   a. Satisfied (0)
   b. Neither satisfied nor dissatisfied (1)
   c. Dissatisfied (2)

3) Who manages your money day-to-day?
   a. I do, without any help. (0)
   b. I get help from someone (1)
   c. Someone else manages all my money (2)

4) How satisfied are you with this money management arrangement?
   a. Satisfied (0)
   b. Neither satisfied nor dissatisfied (1)
   c. Dissatisfied (2)

5) How confident are you in making big financial decisions?
   a. Confident (0)
   b. Unsure (1)
   c. Not confident (2)

6) How often do you worry about financial decisions you've recently made?
   a. Never or rarely (0)
   b. Sometimes (1)
   c. Often (2)

7) Have you noticed any money taken from your bank account without your permission?
   a. No (0)
   b. Yes (1)

8) How often do your monthly expenses exceed your regular monthly income?
   a. Never or rarely (0)
   b. Sometimes (1)
   c. Often (2)

9) How often do you talk with or visit others on a regular basis?
   a. Daily or weekly (0)
   b. Monthly (1)
   c. Less than monthly (2)

10) How often do you wish you had someone to talk to about financial decisions, transactions, or plans?
   a. Never or rarely (0)
   b. Sometimes (1)
   c. Often (2)

11) How often do you feel anxious about your financial decisions and/or transactions?
   a. Never or rarely (0)
   b. Sometimes (1)
   c. Often (2)

12) Do you have a confidante with whom you can discuss anything, including your financial situations and decisions?
   a. Yes (0)
   b. No (1)

13) How often do you feel downhearted or blue about your financial situation or decisions?
   a. Never or rarely (0)
   b. Sometimes (1)
   c. Often (2)

14) *Are your memory, thinking skills, or ability to reason with regard to financial decisions or financial transactions worse than a year ago?
   a. No (0)
   b. Yes (1)

15) Has a relationship with a family member or friend become strained due to finances as you have gotten older?
   a. No (0)
   b. Yes (1)

16) Did anyone ever tell you that someone else you know wants to take your money?
   a. No (0)
   b. Yes (1)

17) How likely is it that anyone now wants to take or use your money without your permission?
   a. Unlikely (0)
   b. Somewhat likely (1)
   c. Very likely (2)

Version 1/19/21

96

OlderAdultNestEgg.com | Financial Vulnerability Survey

Instructions: Circle one answer per question

1) How worried are you about having enough money to pay for things?

a. Not at all worried (0**)** **b.** Somewhat worried (1) **c.** Very Worried (2)

2) Overall, how satisfied are you with your finances?

a. Satisfied (0**)** **b.** Neither satisfied nor dissatisfied (1) **c.** Dissatisfied (2)

3) Who manages your money day-to-day?

a. I do, without any help(0**)** **b.** I get help from someone (1)

c. Someone else manages all my money (2)

97

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4) How satisfied are you with this money management?

a. Satisfied (0**)** **b.** Neither satisfied nor dissatisfied (1) **c.** Dissatisfied (2)

5) How confident are you in making big financial decisions?

a. Confident (0**)** **b.** Unsure (1) **c.** Not Confident (2)

6) How often do you worry about financial decisions you've recently made?

a. Never or rarely (0**)** **b.** Sometimes (1) **c.** Often (2)

98

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7) Have you noticed any money taken from your bank account without your permission?

a. No (0**)** **b.** Yes (1)

8) How often do your monthly expenses exceed your regular monthly income?

a. Never or rarely (0**)** **b.** Sometimes (1) **c.** Often (2)

9) How often do you talk with or visit others on a regular basis?

a. Daily or weekly (0**)** **b.** Monthly (1) **c.** Less than monthly (2)

99

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10) How often do you wish you had someone to talk to about financial decisions, transactions, or plans?

a. Never or rarely (0**)** **b.** Sometimes (1) **c.** Often (2)

11) How often do you feel anxious about your financial decisions and/or transactions?

a. Never or rarely (0**)** **b.** Sometimes (1) **c.** Often (2)

12) Do you have a confidante with whom you can discuss anything, including your financial situations and decisions?

a. Yes (0**)** **b.** No (1)

100

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13) How often do you feel downhearted or blue about your financial situation or decisions?

a. Never or rarely (0) **b.** Sometimes (1) **c.** Often (2)

14) Are your memory, thinking skills, or ability to reason with regard to financial decisions or financial transactions worse than a year ago?

a. No (0) **b.** Yes (1)

15) Has a relationship with a family member or friend become strained due to finances as you have gotten older?

a. No (0) **b.** Yes (1)

101

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16) Did anyone ever tell you that someone else wants to take your money?

a. No (0) **b.** Yes (1)

17) How likely is it that anyone now wants to take or use your money without your permission?

a. Unlikely (0) **b.** Somewhat likely (1) **c.** Very likely (2)

102

Clinical Gerontologist

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Examining the Validity of the Financial Exploitation Vulnerability Scale

Peter A. Lichtenberg, Maggie Tocco, Juno Moray & Latoya Hall

To cite this article: Peter A. Lichtenberg, Maggie Tocco, Juno Moray & Latoya Hall (2021): Examining the Validity of the Financial Exploitation Vulnerability Scale, Clinical Gerontologist, DOI: 10.1080/07317115.2021.1954124

To link to this article: https://doi.org/10.1080/07317115.2021.1954124

https://www.OlderAdultNestEgg.com

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103

Study of first 240 older adults completing the Survey on our website

Main hypothesis: Those with perceived memory loss will have significantly higher FEVS scores

104

Table 1. Sample demographics across financial vulnerability risk levels.

	Total	Low	Moderate	High	Statistic
Age	71.9 (6.7)	71.5 (5.9)	72.6 (7.8)	73.2 (8.8)	$F(2,255) = 1.12$
Gender					
Male	124 (48.1%)	91 (73.4%)	21 (16.9%)	12 (9.7%)	$\chi^2(2) = 1.87$
Female	134 (51.9%)	88 (65.7%)	28 (20.9%)	18 (13.4%)	
Education					
Bachelor's and below	127 (49.2%)	84 (66.4%)	25 (19.7%)	18 (14.2%)	$\chi^2(2) = 2.43$
Graduate Education	129 (50.0%)	95 (73.6%)	23 (17.8%)	11 (8.5%)	
Living Alone					
Yes	**98 (38.0%)**	**61 (62.2%)**	**19 (19.4%)**	**18 (18.4%)**	**$\chi^2(2) = 7.35$* = 0.17**
No	**160 (62.0%)**	**118 (73.8%)**	**30 (18.8%)**	**12 (7.5%)**	
Memory Complaints					
Yes	**99 (38.4%)**	**53 (53.5%)**	**25 (25.3%)**	**21 (21.2%)**	**$\chi^2(2) = 21.82$** = 0.29**
No	**159 (61.6%)**	**126 (79.2%)**	**24 (15.1%)**	**9 (5.7%)**	

*Comparison is significant at the 0.05 level.
**Comparison is significant at the 0.001 level.

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105

Table 4. Factorial ANOVA for FEVS.

	Living Alone	
Memory Complaints	Yes (n= 98)	No (n= 160)
Yes (n= 99)	**8.26 (5.46, n= 38)**	**5.20 (3.71, n= 61)**
No (n= 159)	3.97 (2.99, n= 60)	3.07 (3.36, n= 99)

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106

Decision Guide for Professionals Administering the Financial Vulnerability Survey (FVS)

Instructions For the FVS

1) Recommended for persons age 50 and up
2) Clients can complete it themselves or it can be administered by trained staff
3) Only one answer should be marked for each question
4) Survey is scored by adding the numbers in parenthesis after each answer
5) Critical items #7, 10, 11, 13, 14, 15, 16 that score as "Often" or "Yes" should be probed to determine financial exploitation (FE) (see below)
6) Scores above 5 have been associated with a higher likelihood of financial exploitation.

FVS SCORING

0 - 4 = Low Risk
- SAFE education t protect assets manage money
- Take the FVS every 6-12 months t0 monitor your risk

5 - 9 = Average Risk
- Administer Financial Decision Tracker if indicate (olderadultnestegg.com)
- If financial or relationship strain exists around money consider referral to SAFE and/or mediation services
- Follow-up on critical items. If FE is indicated, refer to APS.
- Encourage client to make changes to protect against FE

10+ = High Risk
- Administer the Financial Decision Tracker if indicated (olderadultnestegg.com)
- If financial or relationship strain around money, consider referral to SAFE and/or mediation services
- Follow-up on critical items. If FE exists, refer to APS.
- Encourage client to make changes to protect against FE

Critical Questions Follow-up

#7 - Have you noticed money taken from your bank account without permission? **If YES:** who, when, how much?

#10 - How often do you wish you had someone to talk to about financial decisions, transaction or plans? **If OFTEN**: Consider referral to SAFE program or financial coaching.

#11 - How often do you feel anxious about your financial decisions and/or transactions? **If OFTEN**: Do you feel anxious in other ways, explain. Consider referral for mental health treatment.

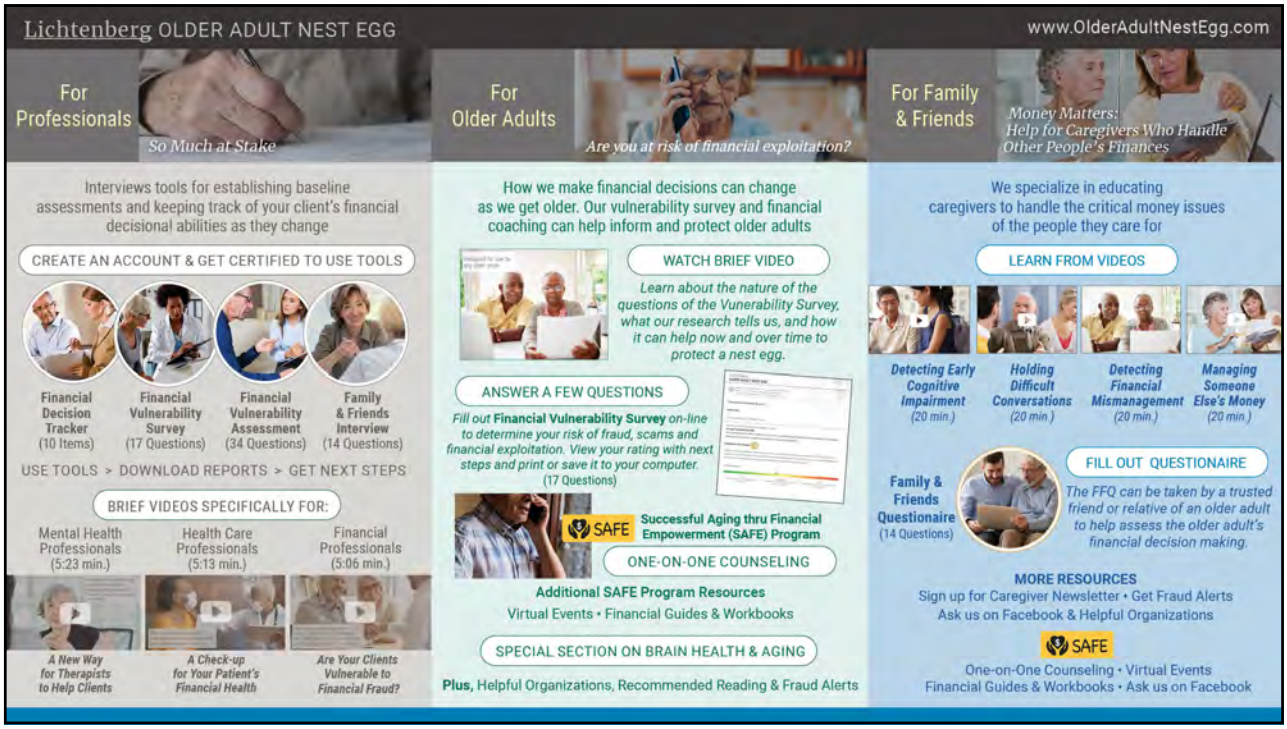
#13 - How often do you feel downhearted or blue about your financial situation or decisions? **If OFTEN:** Consider referral for mental health treatment

#14 - Are your memory, thinking skills, or ability to reason regarding financial decisions or financial transactions worse than a year ago? **If YES**, first probe to understand how cognitive decline has impacted finances. Consider referral for cognitive evaluation and/or dementia work-up.

#15 - Has a relationship with a family member of friend become strained due to finances as you have gotten older? **If YES**: Who? To what degree? Details. Determine if FE may be present.

#16 - How likely is it that anyone now wants to take or use your money without your permission? If VERY LIKELY: Who? Why do you thin that? Determine if FE may be present.

107



108

Older Adult Nest Egg Website

4-year Statistics

Total number of training sessions completed

4,859

Scales Administered

FDT = 2,139

FVS = 1,908
(only on site past 2 years)

All Scales = 4,793
(includes FVA & FFI)

https://olderadultnestegg.com

109

Innovation in Aging
cite as: *Innovation in Aging*, 2022, Vol. 6, No. 5, 1–8
https://doi.org/10.1093/geroni/igac038
Advance Access publication May 26, 2022

Latest Discovery

The WALLET Study: Examining Early Memory Loss and Personal Finance

Peter A. Lichtenberg, PhD, ABPP,[1,*] Wassim Tarraf, PhD,[1,2] Vanessa O. Rorai, MSW,[1] Matthew Roling, MBA,[3] Juno Moray, MA,[1] Evan Z. Gross, PhD,[4] and Patricia A. Boyle, PhD[5]

[1]Institute of Gerontology, Wayne State University, Detroit, Michigan, USA. [2]Department of Healthcare Sciences, Wayne State University, Detroit, Michigan, USA. [3]School of Business, Wayne State University, Detroit, Michigan, USA. [4]Rehabilitation Institute of Michigan, Detroit, Michigan, USA. [5]Rush Alzheimer Disease Center, Rush University Medical Center, Chicago, Illinois, USA.

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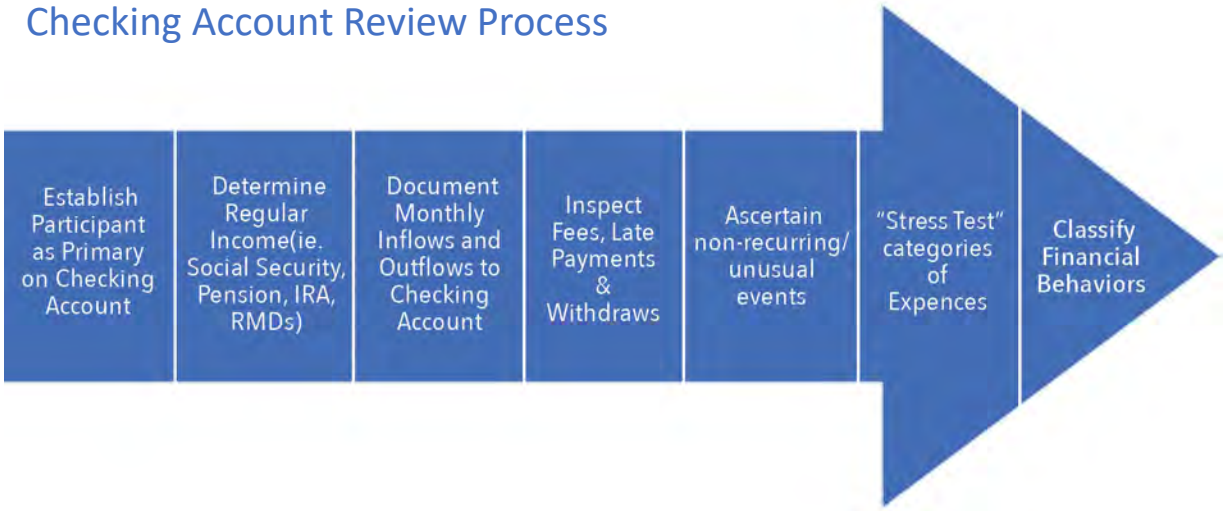
110

PUPOSE OF THE STUDY

This feasibility study was designed to examine a person-centered approach to assessment of the daily financial management aspects of personal finance in older persons with early memory loss.

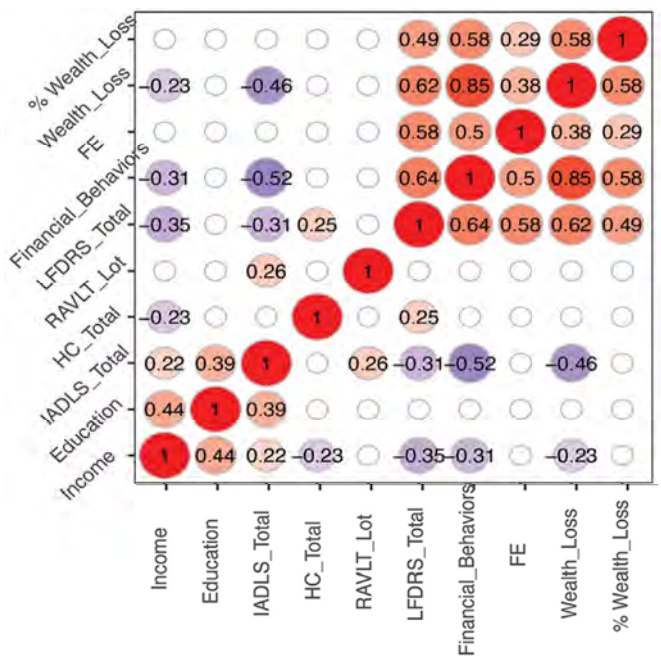
111

WALLET: Checking Account Review Process



iog.wayne.edu/walletstudy | OlderAdultNestEgg.com

112



Correlation Plot

(P<.2 presented in plot)

Figure 1 – Notes: FE = financial exploitation; LFDRS = Lichtenberg Financial Decision Rating Scale; RAVLT LoT = Rey Auditory Verbal Learning Test Learning over Trial; HC = health conditions; IADLS = instrumental activities of daily living scale. Financial behavior index = count of the fol-lowing: missed bills, late fees, regular financial assistance to others, and overpayment in one expenditure category. Corresponding correla-tion matrix values are presented in Supplementary Table 1.

113

Table 2. Association Between Financial Behaviors, LFDRS, FEVS and (1) Financial Exploitation and (2) Wealth Loss

		Financial exploitation		% Wealth loss	
Variable		OR	(95% CI) *p* value	*b*	(95% CI) *p* value
Model 1	Financial behaviors index	2.48	(1.21;5.09) *p* = .013	12.18	(5.89;18.46) *p* < .001
Model 2	Financial behaviors index	2.29	(1.04;5.01) *p* = .039	11.28	(5.49;17.06) *p* < .001
Model 3	Financial behaviors index	1.89	(0.8;4.47) *p* = .145	10.82	(3.15;18.49) *p* = .007
	LFDRS	1.16	(1.01;1.34) *p* = .042	0.15	(−1.21;1.51) *p* = .821

Model 1: Adjusts for income, education, and MCI/PCI status.

Model 2: Additionally adjusts for cognitive function(Rey Auditory Verbal Learning Test Learning over Trial [RAVLT LoT]) and IADLs.

Model 3: Adds the LFDRS. LFDRS = Lichtenberg Financial Decision Rating Scale; OR = odds ratio; CI = confidence interval; FEVS = Financial Exploitation Vulnerability Survey; MCI = mild cognitive impairment; PCI = perceived cognitive impairment; IADL = instrumental activities of daily living.

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114

Summary

New conceptual model and evidence-based scales to assess informed financial decision-making for a specific decision.

Our experience with Implementation Science

Financial Vulnerability and Financial Exploitation:

Our 17-item self-report measure

SAFE program

https://Olderadultnestegg.com

115

Sharing What We Learn: Talking with Older Adults about the Results of Alzheimer's Testing

Annalise Rahman-Filipiak, PhD
Assistant Professor & Clinical Neuropsychologist,
University of Michigan
Michigan Alzheimer's Disease Research Center

How health information is communicated, such as a new diagnosis of mild cognitive impairment or dementia – Alzheimer's type, is an important predictor of wellbeing and how well medical recommendations are followed. The sensitive disclosing of these results can also be a tool for building rapport with patients and research participants, especially when it enlists bi-directional communication and partnership. Dr. Rahman-Filipiak will review the current literature about providing neuropsychological and diagnostic feedback to older adults and their families. She will also discuss ethical and practical challenges in disclosing information about Alzheimer's disease biomarkers to a range of patients from cognitively symptomatic to asymptomatic. The discussion will focus on how social determinants mandate person-centered and culturally informed protocols rather than a 'one-size-fits-all' approach.

Michigan ADRC
Alzheimer's Disease Research Center

RP-CNBI
Research Program on Cognition and Neuromodulation Based Interventions

Sharing What We Learn: Talking with Older Adults about the Results of Alzheimer's Disease Testing

Annalise Rahman-Filipiak, PhD (she/her)
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Research Program on Cognition & Neuromodulation Based Interventions
Department of Psychiatry – Neuropsychology Section, University of Michigan
Michigan Alzheimer's Disease Research Center

1

Disclosures/COI

No relevant disclosures.

2

Alzheimer's Disease & Dementia – Alzheimer's Type

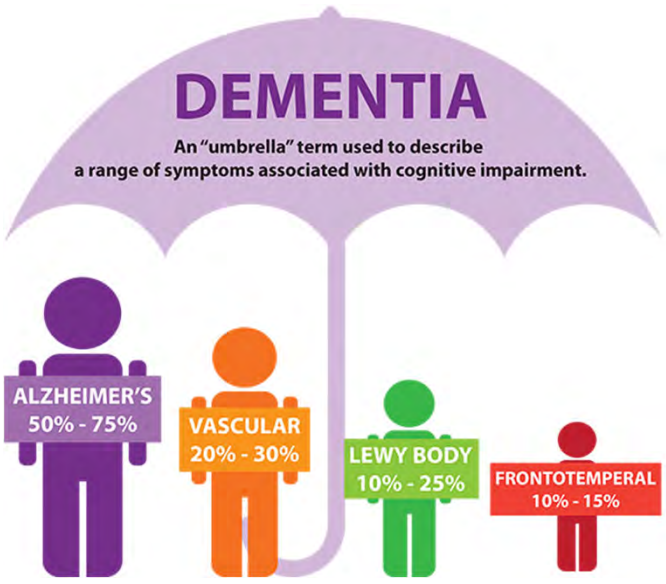
3

What is Dementia?

- **Dementia is a <u>general</u> term for brain disorders that affect cognition, mood, personality, and behavior.**
  - Symptoms <u>worsen</u> over time.
  - Difficulties are noticeable to the individual and/or their loved ones, AND on formal testing.
  - Symptoms make it difficult to complete tasks needed to take care of yourself independently (e.g., driving, managing medications, handling finances, and preparing meals).
  - In later stages, symptoms also affect basic activities (e.g., bathing and hygiene, dressing, and eating).

4

Causes of Dementia



- Different forms of dementia are characterized by different trajectories, cognitive, behavioral, motor, and emotional symptoms.
- Dementia Alzheimer's Type (DAT) is the most common form of dementia, caused by Alzheimer's disease.
- However, it is possible to have multiple underlying 'etiologies' (causes) of symptoms.

5

What is Alzheimer's Disease?

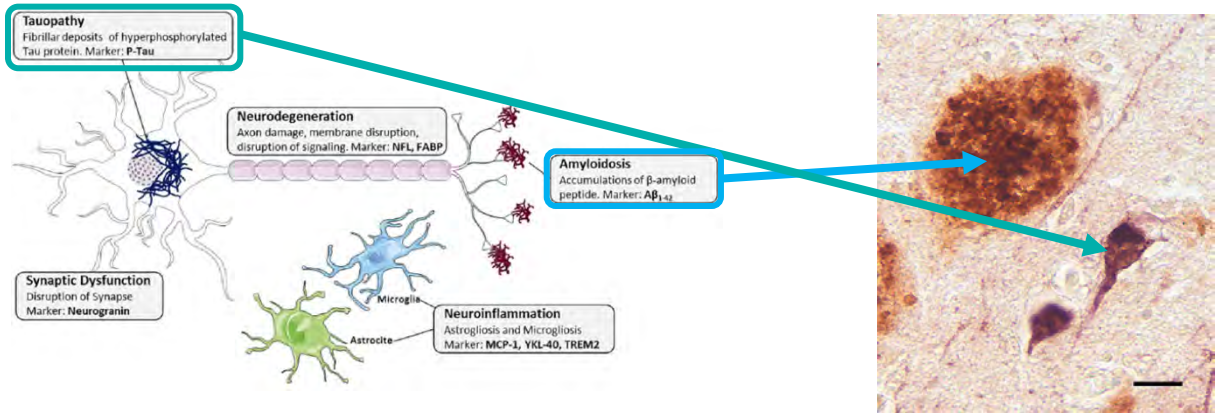
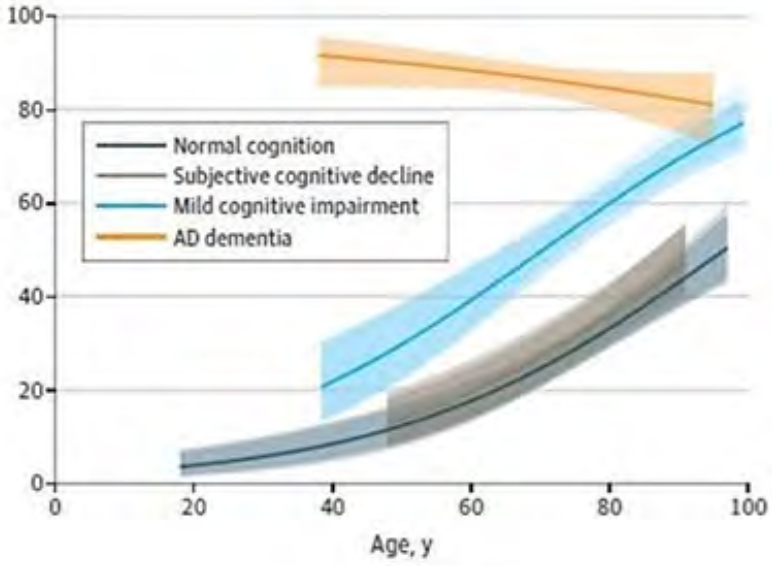


Figure adapted from Janeiro et al. (2020) https://doi.org/10.1515/almed-2020-0090

6

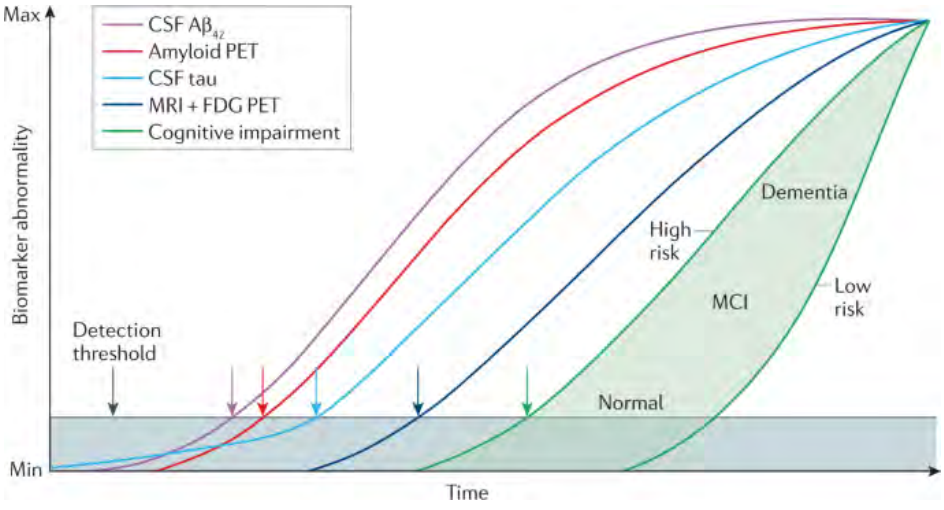
Amyloid in Healthy Older Adults



Jansen et al. (2022) *JAMA Neurology*

7

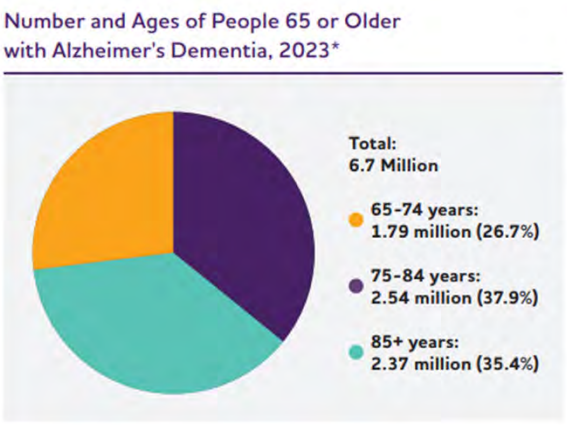
The Alzheimer's Disease Continuum

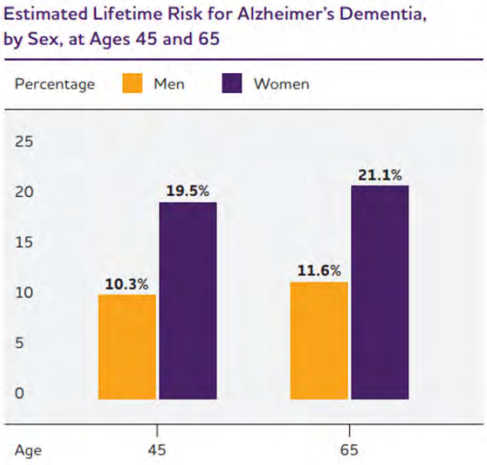


Normal (Low pathology and symptoms)	Preclinical AD	Mild Cognitive Impairment (MCI) due to AD	Dementia of the Alzheimer's Type (DAT)

8

Alzheimer's Disease Prevalence

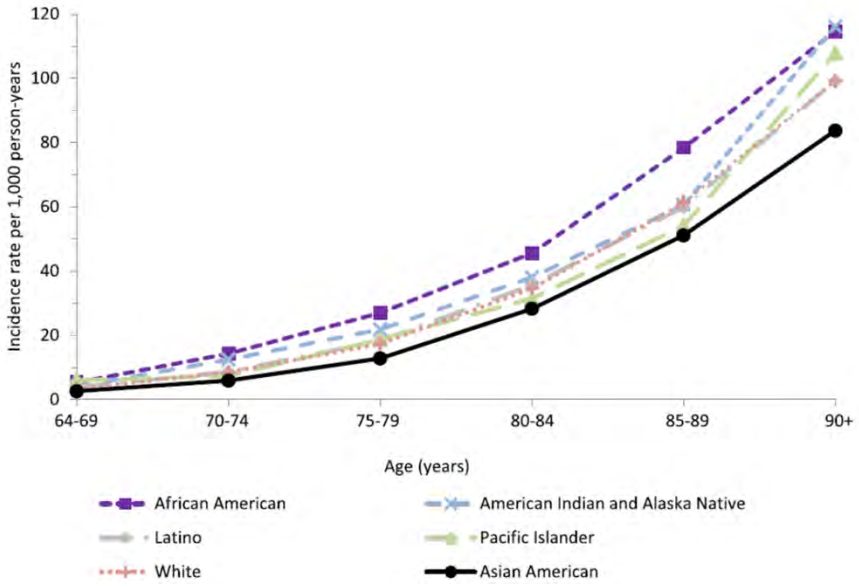




- 6.7 million Americans are living with Dementia – Alzheimer's Type (DAT)
- Women are at approximately twice the risk of DAT as men.

9

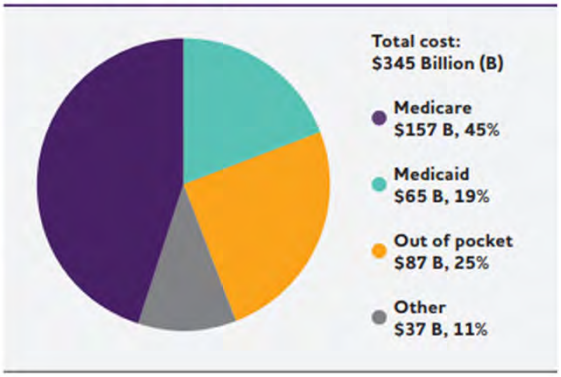
Racial Disparities in Dementia Prevalence



10

Costs of Dementia – Alzheimer's Type

Distribution of Aggregate Costs of Care by Payment Source for Americans Age 65 and Older with Alzheimer' or Other Dementias, 2023*



Average Annual per-Person Payments by Type of Service for Health Care and Long-Term Care Services, Medicare Beneficiaries Age 65 and Older, with and without Alzheimer's or Other Dementias, in 2022 Dollars

Payment Source	Beneficiaries with Alzheimer's or Other Dementias	Beneficiaries without Alzheimer's or Other Dementias
Inpatient hospital	$7,316	$2,738
Outpatient events	2,876	2,263
Medical provider*	5,936	3,832
Skilled nursing facility	3,694	372
Nursing home	13,623	527
Hospice	2,328	136
Home health care	1,863	275
Prescription medications**	4,811	3,245

11

Costs of Dementia-Alzheimer's Type

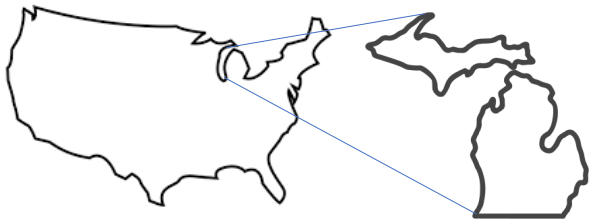
Average Annual Per-Person Payments by Type of Service and Race/Ethnicity for Medicare Beneficiaries Age 65 and Older, with Alzheimer's or Other Dementias, in 2022 Dollars

Race/Ethnicity	Total Medicare Payments Per Person	Hospital Care	Physician Care	Skilled Nursing Care	Home Health Care	Hospice Care
White	$22,203	$5,636	$3,713	$3,130	$1,918	$4,150
Black	27,686	8,765	4,514	4,120	1,976	2,919
Hispanic	25,611	7,626	4,284	3,573	2,379	3,427
Other	22,759	7,065	3,904	3,479	1,965	2,826

Created from unpublished data from the National 100% Sample Medicare Fee-for-Service Beneficiaries for 2019.[382]

12

Caregiving Costs of DAT



- 11,479,000 Americans serve as unpaid caregivers, resulting in $340 billion in lost wages
- 380,000 Michiganders serve as unpaid caregivers, resulting in $17 billion in lost wages

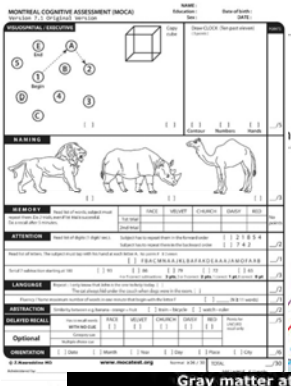
- Black care partners are more likely to provide full-time (>40h/week) care
- Black care partners are less likely to use respite care services
- Black, Hispanic, and Asian American care partners have greater care demands, less formal assistance, and greater depression.

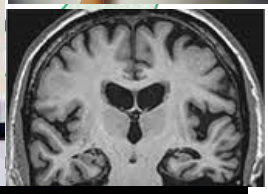
13

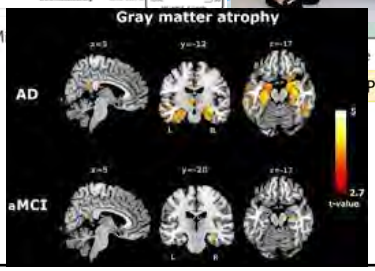
What kind of testing is available for Alzheimer's disease and related dementias?

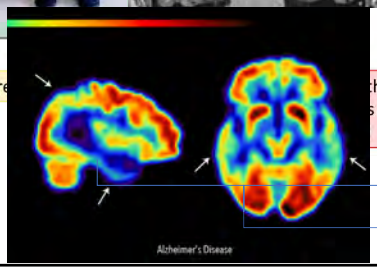
14

Alzheimer's Disease Diagnosis









Current **clinical testing** is targeted at detecting cognitive/neurologic impairment and neurodegeneration:

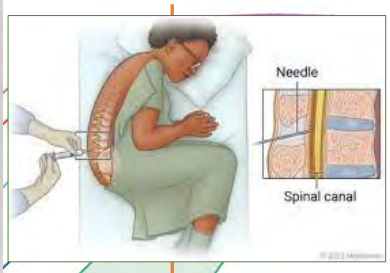
- Clinical Interview
- Cognitive Screening (MoCA, MMSE)
- Specialty care referral:
  - Neurologic Examination
  - Neuropsychological Evaluation
  - Structural Magnetic Resonance Imaging (MRI)
  - Standard Bloodwork

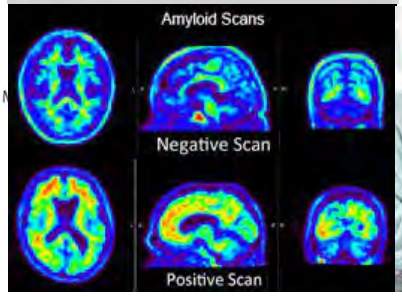
Rarely:

- Functional MRI
- FDG-PET

15

Alzheimer's Disease Diagnosis





Tests are available that may detect individuals <u>at genetic risk for</u> Alzheimer's disease:

- APP
- PSEN1, PSEN2
- APOE

Newer tests may detect whether an individual has amyloid, tau, or other **biomarkers** for Alzheimer's disease prior to symptom onset.

- Cerebrospinal Fluid
- Amyloid/Tau Positron Emission Tomography
- Blood Biomarker Testing

16

Great!
Can I get a biomarker test or order one for my patient?

17

Return of Alzheimer's Disease Research Results

TABLE 1 Return of individual research results, by type (N = 30 centers)

Type of information	Type of participant: Dementia or MCI	Normal cognition or SMC	N/A
Consensus research diagnosis	25 (83%)	23 (77%)	0
Neuropsychological test results	22 (73%)	21 (70%)	0
Amyloid PET results	13 (43%)	8 (27%)	6 (20%)
MRI results	12 (40%)	10 (33%)	3 (10%)
FDG PET results	8 (27%)	6 (20%)	10 (33%)
Genetic test results, not *APOE*	4 (13%)	3 (10%)	5 (17%)
Tau imaging results	3 (10%)	2 (7%)	13 (43%)
CSF biomarker results	3 (10%)	1 (3%)	8 (27%)
APOE genetic test results	2 (7%)	2 (7%)	0

Roberts et al. (2021) *Alz Dem: TRCI*

18

Practical Challenges to Biomarker Testing

19

Research Challenges for Biomarker Testing

- Different ligands, data collection and analytic methods
- No agreed upon cut-point for ‘positivity’; visual rating still common
- Few published protocols or centralized post-disclosure resources
- Lacking actuarial methods for combining risk indicators/biomarkers and clinical/behavioral data
- Limited research with racial-ethnic minorities (and some evidence of differential meaning of biomarkers in non-White communities)

20

Communication Challenges for Biomarker Testing

Etiology vs. Phenotype	Alzheimer's Disease	≠	Dementia – Alzheimer's Type
Context	Research Results	≠	Clinical Diagnosis
Dynamic Nature	Currently Not Elevated	≠	Permanently Not Elevated
Prognosis	Elevated Results	≠	Definitive Dementia Prognosis
Contribution to Clinical Picture	Elevated Results	≠	Ruling Out Other Conditions/Contributors

21

Benefits of Returning Research Results

- Participant rights (Walter et al., 2022, *JAD*)
  - Respect for autonomy
  - Right to Know (or Not)

- Motivating meaningful change, regardless of result
  - Diagnosis, treatment planning, and monitoring
  - Health behaviors
  - Advanced planning
  - Role preparation

22

Benefits of Returning Research Results

Reasons for participating	Factor 1 (personal benefit)	Factor 2 (altruism)
To advance AD research	−0.04	0.79
To benefit society	0.09	0.78
To benefit future generations of own family	0.21	0.59
Because I have concerns about memory	0.62	−0.11
To gain access to future treatments	0.72	0.11
To learn more about AD	0.60	0.21
To enjoy time with staff	0.43	0.19
To access medical center support	0.80	0.04

Participants reasons for recruitment and retention in AD longitudinal studies can be grouped into two categories: ***altruistic (benefits to science/society)*** and ***personal (benefits to self/family)***

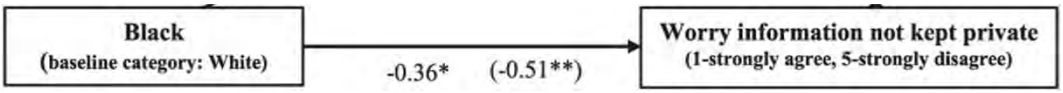
Participants with impairment emphasize personal benefits more and altruism less.

Black and Asian participant emphasize personal benefits more.

Gabel et al. (2022) *JAD*

23

Benefits of Returning Research Results



Return of research results may **heighten personal benefits** and **reduce mistrust in research**, ultimately leading to better recruitment and retention, especially among participants from minoritized communities.

Gabel et al. (2022) *JAD*

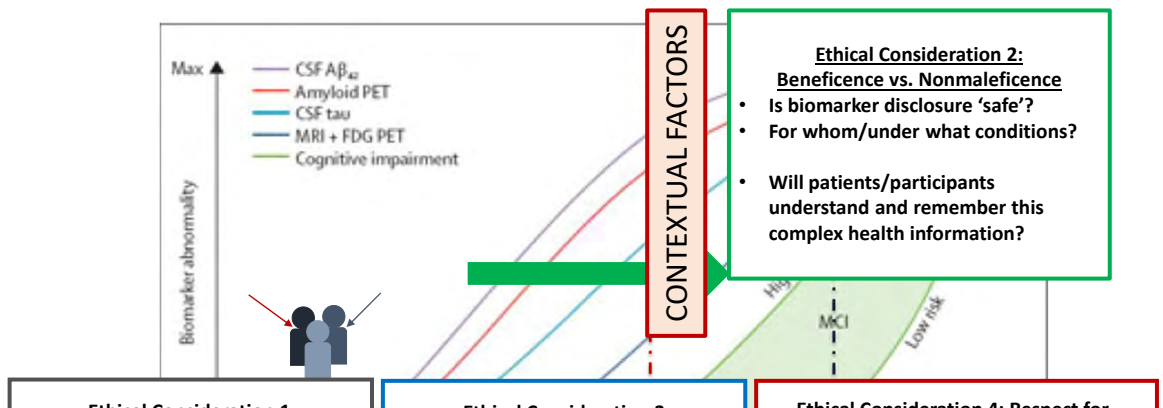
24

Ethical & Cultural Considerations for Disclosing Alzheimer's Disease Biomarkers Results

Michigan ADRC
Alzheimer's Disease Research Center

RP-CNBI

25



CONTEXTUAL FACTORS

Ethical Consideration 1: The 'Right to Know' vs. 'Desire not to Know'

- Symptomatic vs. asymptomatic individuals
- Participants vs. Patients
- 'Patients' vs. Care Partners

Ethical Consideration 2: Beneficence vs. Nonmaleficence

- Is biomarker disclosure 'safe'?
- For whom/under what conditions?
- Will patients/participants understand and remember this complex health information?

Ethical Consideration 3: Protection against Risks vs. Respect for Autonomy

- Do patients/participants have decisional capacity to engage in biomarker disclosure?

Ethical Consideration 4: Respect for Cultural Diversity

- Do risk disclosure needs differ across groups?
- How to social determinants of health impact development of biomarker disclosure protocols?

26

What data do we need before we can share biomarker results responsibly, safely, and equitably?

1. **Evaluate the Need**
Do our participants and their families want to know their research results, including biomarker status?

Why or Why Not?

27

Do participants want their PET Amyloid & Tau Results?

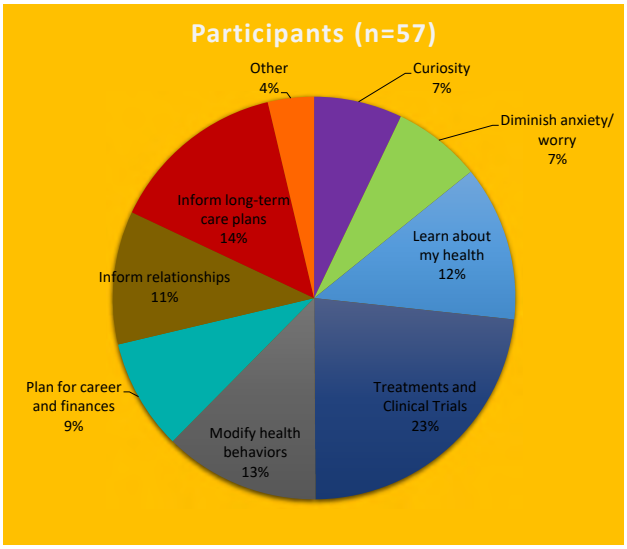
		Participants (*n* = 57)			Co-Participants (*n* = 57)		
		Black (*n* = 22)	White (*n* = 35)	*p*	Black (*n* = 19)	White (*n* = 38)	*p*
Interest in receiving PET amyloid & tau results	No Interest	0 (0.0%)	1 (2.9%)		1 (5.3%)	0 (0.0%)	
	Very Little Interest	0 (0.0%0	0 (0.0%)		2 (10.5%)	0 (0.0%)	
	Neutral	0 (0.0%)	0 (0.0%)		1 (5.3%)	3 (7.9%)	
	Moderate Interest	3 (13.6%)	6 (17.1%)		2 (10.5%)	1 (2.6%)	
	Strong Interest	19 (86.4%)	28 (80.0%)	.835	13 (68.4%)	34 (89.5%)	.047*
	Average Score	3.86 (0.35)	3.71 (0.75)	.386	3.26 (1.28)	3.82 (0.56)	.027*
Would you choose to receive PET amyloid & tau results today?	Yes	22 (100.0%)	34 (97.1%)	.999	15 (79.0%)	36 (94.7%)	.164

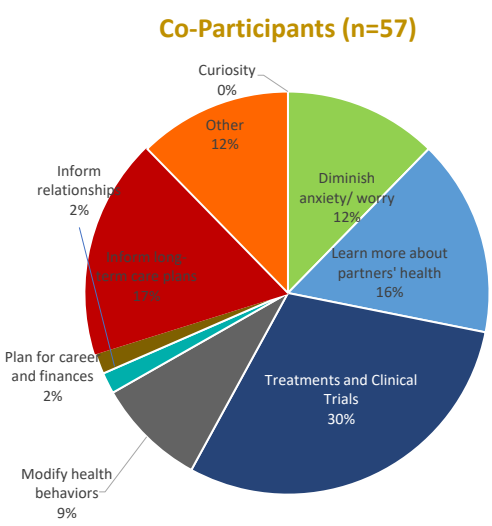
- Participants report high interest in PET biomarker results regardless of race or diagnosis.
- Co-participants report moderate interest; however, white participants reported greater interest and willingness to receive the participant's PET results than Black participants.

Rahman R03, *under review*

28

Why do participants want to know?



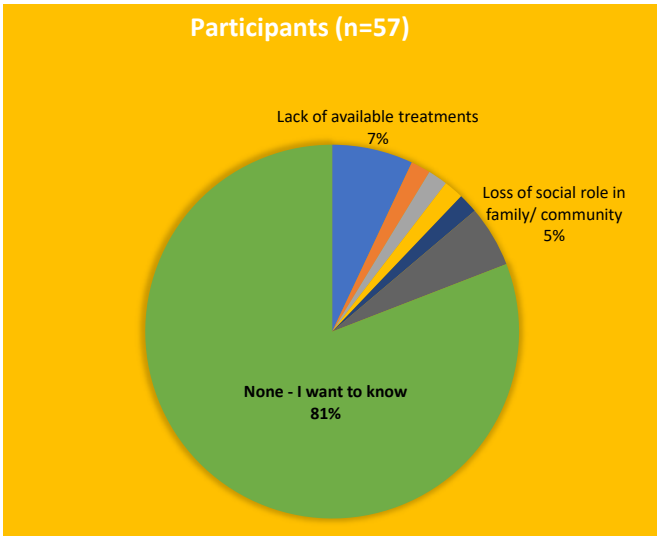


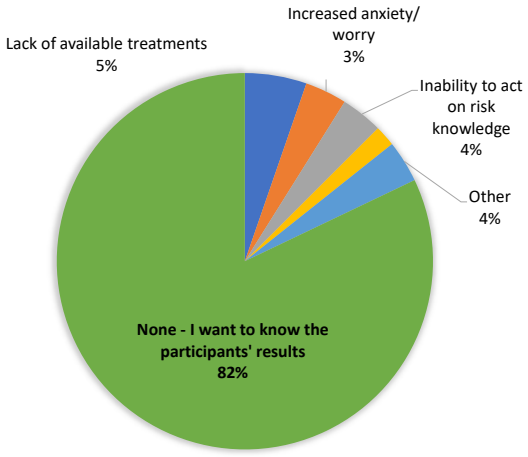
- Reasons for biomarker disclosure are highly diverse and personalized…disclosure protocols must respond to these varied needs.

Rahman R03, *under review*

29

Why not?



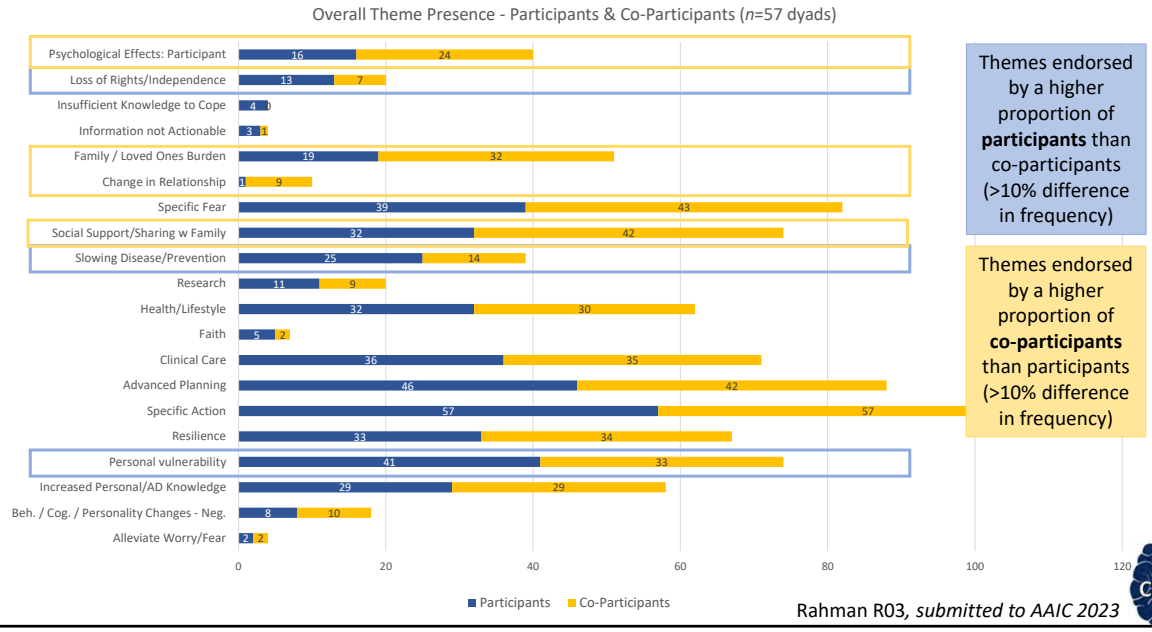


- Participants overwhelmingly desire this information, even after acknowledging the risks.

Rahman R03, *under review*

30

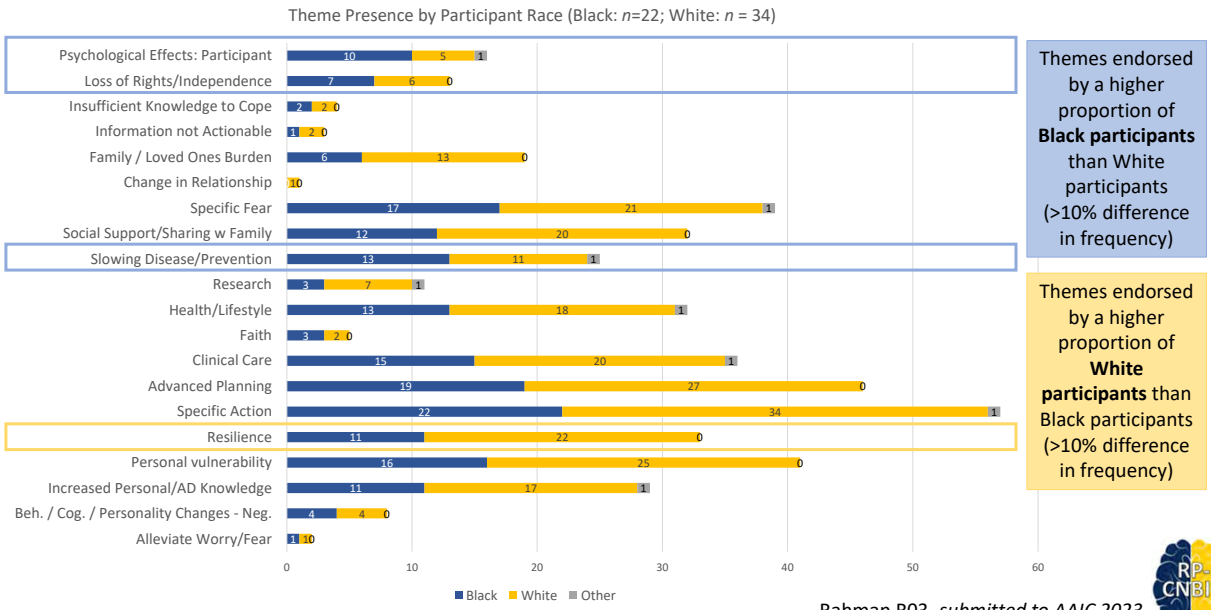
Qualitative Insights



Rahman R03, *submitted to AAIC 2023*

31

Qualitative Insights



Rahman R03, *submitted to AAIC 2023*

32

What data do we need before we can share biomarker results responsibly, safely, and equitably?

1. Evaluate the Need
Do our participants and their families want to know their AD biomarker status?

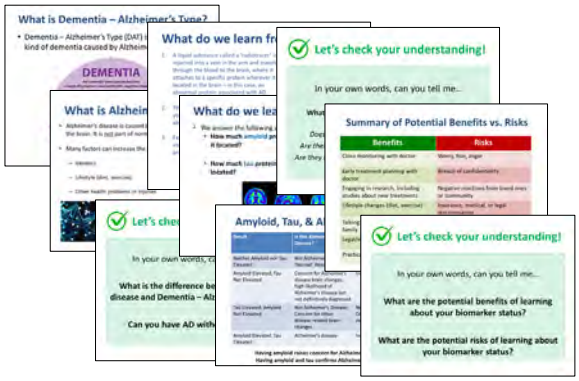
YES, but benefits and risks/concerns vary greatly

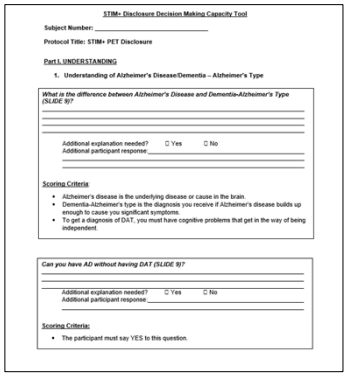
2. Determine Safety
Can symptomatic participants make informed decisions about disclosure?

Does disclosure result in distress, suicidality, or other adverse events?

33

Can participants with cognitive impairment make informed decisions about receiving their results?





- Prior to disclosure, participants and their care partner(s) complete an interactive education session.
- The education session includes embedded decisional capacity questions.
- If the participant fails any one question, the care partner may respond.
- If either independent or shared decisional capacity for disclosure is demonstrated, the dyad move forward to disclosure.

Ongoing Bioethics administrative supplement to Hampstead STIM R01

34

Can participants with cognitive impairment make informed decisions about receiving their results?

Participants (*n*=52)	MCI (*n*=33)	DAT (*n*=19)	Chi-Sq	*p*
Understanding Demonstrated	25 (75.76%)	5 (26.32%)	12.08	**.001***
Appreciation Demonstrated	26 (78.79%)	8 (42.11%)	7.17	**.009***
Rationale Demonstrated	30 (90.91%)	14 (73.68%)	2.75	.106
Choice Demonstrated	32 (96.97%)	17 (89.47%)	1.25	.299
OVERALL CAPACITY DEMONSTRATED	25 (75.76%)	5 (26.32%)	12.08	**.001***

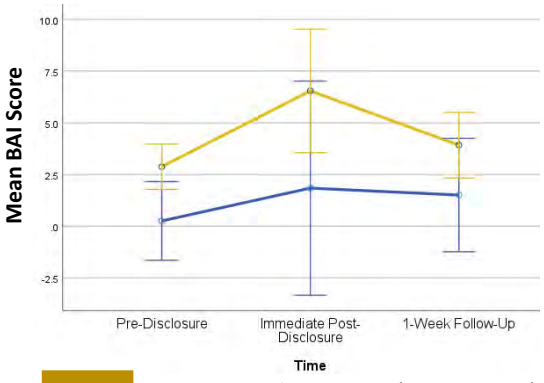
- Individuals with **MCI were better able to demonstrate understanding, appreciation, and overall disclosure decisional capacity** than those with DAT.
- Among participants who required assistance of shared decision-makers, **all co-participants were able to demonstrate decisional capacity**.
- Implications for clinical care: how/with whom we assess decisional capacity

Ongoing Bioethics administrative supplement to Hampstead STIM R01

35

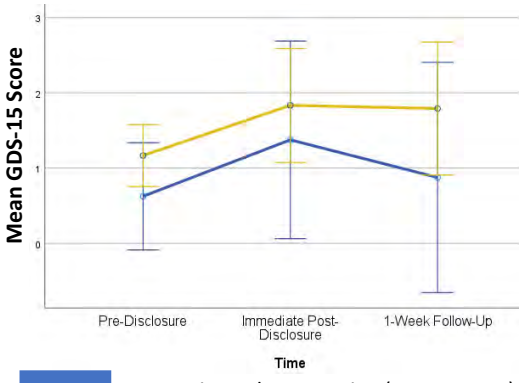
Is biomarker disclosure safe?

Beck Anxiety Inventory
(0-63, >16 moderate anxiety)



AD Biomarker Positive (A+T+ or A+T-) [*n*=32]

Geriatric Depression Scale – 15
(0-15, >5 clinically significant)



AD Biomarker Negative (A-T+ or A-T-) [*n*=11]

- Statistically but not clinically significant difference in **anxiety post-disclosure** (AD+>AD-).
- **No statistically or clinically significant depression or adverse events**, including suicidal ideation.

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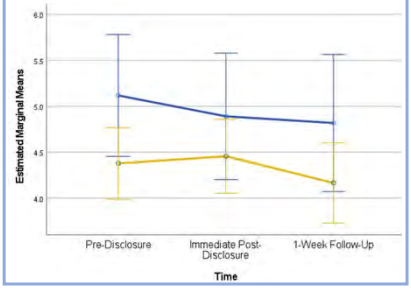
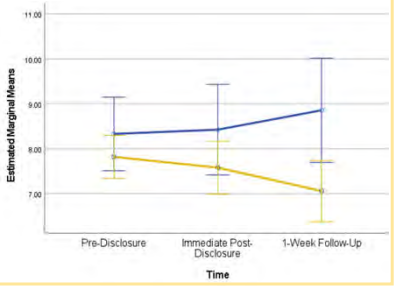
36

What are the psychological impacts?

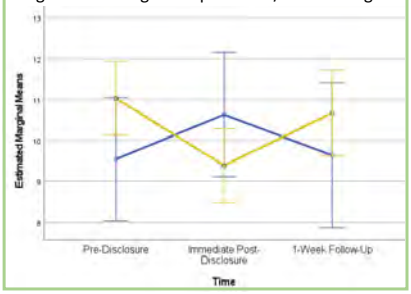
Future Time Perspective (FTP)
Higher scores = more possibilities in the future



Self Efficacy for Managing MCI/Dementia
Higher scores = greater self-efficacy



Stigma Scale for MCI/Dementia
Higher scores = greater perceived/enacted stigma



AD Biomarker Positive (A+T+ or A+T-)[*n*=32] AD Biomarker Negative (A-T+ or A-T-)[*n*=11]

- **Future time perspective** did not significantly change over time, regardless of AD biomarker result
- **Self-efficacy for managing symptoms of MCI/dementia** was significantly lower in those who were amyloid positive, with most notable differences occurring at the 1-week post-disclosure follow-up.
- Amyloid positive participants experience an initial decline in **perceived and experienced stigma** that reverts to baseline at 1-week follow-up; Amyloid negative participants experience the inverse effect. These findings may represent regression to the mean.

Ongoing Bioethics administrative supplement to Hampstead STIM R01

37

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→ **YES, with support**

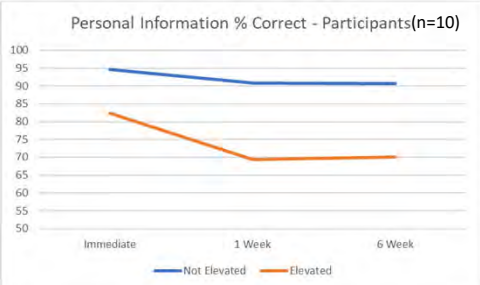
Does disclosure result in distress, suicidality, or other adverse events?
→ **NO, disclosure is well tolerated in those psychologically stable at baseline**

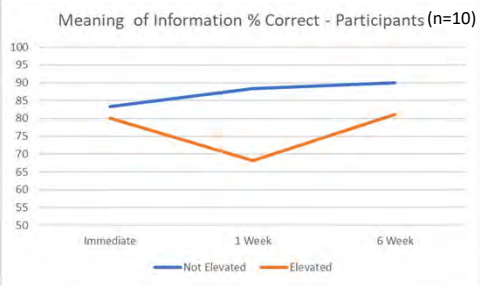
3. Assess Efficacy

Do symptomatic participants understand complex biomarker information and associated risk for dementia?

38

Do participants understand and recall their results?





- Rote recall of results is higher than understanding/recall of the *meaning* of those results.
- Trend towards amyloid positive participants having lower rote recall of their results and more limited understanding of the meaning of their biomarker results over time.
- More data being collected (Bioethics supplement, K23)

Rahman R03, *under review*

39

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4. Measure Utility/Impact
How do participants/families use their biomarker results?

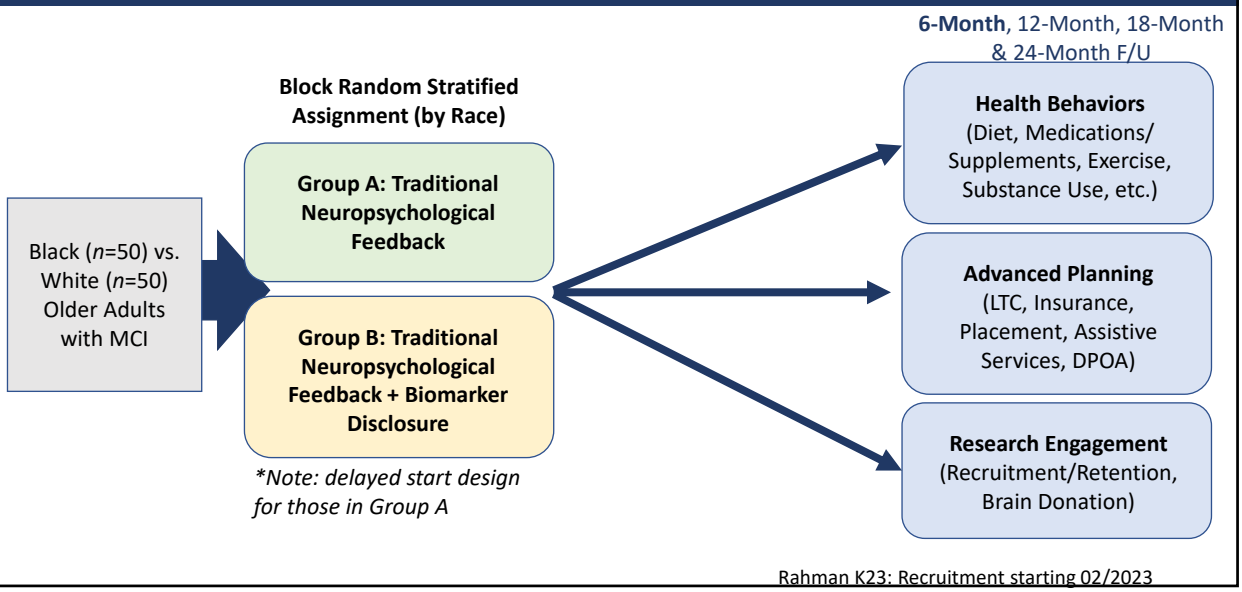
What are the downstream positive and negative effects of early etiologic diagnosis?

5. Understand Moderating and Mediating Factors

What predicts positive vs. negative post-disclosure outcomes (e.g., participant factors, social factors)?

41

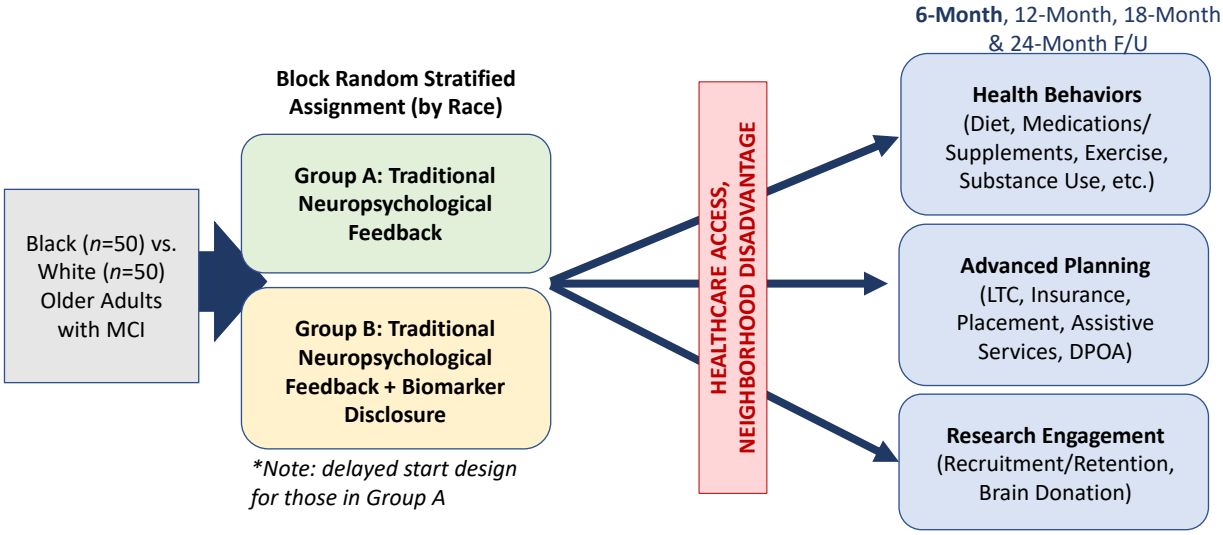
How do participants with elevated vs. non-elevated AD biomarkers use their results over time?



Rahman K23: Recruitment starting 02/2023

42

Do Black and White participants use their results differently? Do social determinants mediate this relationship?



Rahman K23: Recruitment starting 02/2023

43

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How do participants/families use their biomarker results?

What are the downstream positive and negative effects of early etiologic diagnosis?

→ **STAY TUNED!**

5. Understand Moderating and Mediating Factors

What predicts positive vs. negative post-disclosure outcomes (e.g., participant factors, social factors)?

→ **STAY TUNED!**

6. Cultural Adaptation, Dissemination & Implementation

How do we adapt biomarker disclosure to balance feasibility and cultural sensitivity?

44

"Nothing about us without us": Community Engagement to Promote Culturally Sensitive Return of Results

- **Goals:**
  - To enhance recruitment of the diverse population of the Detroit Metro Area in our clinical studies
  - To inform our current and ongoing disclosure protocols through community engaged research practices
  - To build a strong, independent reputation in our community

PAST PARTICIPANT INTERVIEWS

FOCUS GROUPS

COMMUNITY ADVISORY BOARD

COMMUNITY HEALTH EDUCATION

Statewide Building Capacity for Research and Action Award to RP-CNBI (Rahman)

45

Detroit Community Event – January 19th, 2023

RP-CNBI

EASTSIDE COMMUNITY NETWORK

HEALTHIER BLACK ELDERS CENTER

Statewide Building Capacity for Research and Action Award to RP-CNBI (Rahman)

46

Summary & Future Directions

- Return of individual research results may be an important tool for recruitment and retention of diverse participants in ADRD research.
- Participant desire for results is near ubiquitous; however, reasons for wanting or fearing this information are varied, as should be disclosure approaches.
- Shared decision making around disclosure is important, particularly for those with impairment and given the impacts on both participants and their loved ones.
- Disclosure is largely safe for cognitively symptomatic and asymptomatic individuals with stable mental health, but more data is needed in community samples who may have baseline psychiatric symptoms.

47

Summary & Future Directions

- Increased comprehension (not just recall) will require actuarial approaches to integrate risk information are needed and graphical representations of results/risk.
- Little is known about long-term adaptive and maladaptive reactions to disclosure, nor the factors that drive them.
- Collaborative, community-engaged approaches are needed for the cultural adaptation of return of results protocols.

48

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- SHARED I & II (NIA R03-AG063222-01; PI: Rahman)
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- SHARED III (NIA 1K23AG07004401-A1; PI: Rahman)
- Michigan Institute for Clinical Health Research: Statewide Building Capacity for Research and Action Award (SBCRA; PI: Rahman)
- Dissertation Grant, UM SPH (PI: Feldman)

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Participants & Their Families

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- Theresa Gierzynski, MSW
- Haley Kohl, BS

Research Program on Cognition & Neuromodulation-Based Interventions (RP-CNBI)

Community Partners & Advisory Board

Michigan Alzheimer's Disease Research Center (MADRC)

HEALTHIER BLACK ELDERS CENTER

EASTSIDE COMMUNITY NETWORK

49

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50

Healthcare Help for Family Caregivers of Frail Older Adults

Terri Harvath, PhD, RN, FAAN, FGSA
Clinical Professor, School of Nursing,
University of Minnesota

Family caregivers of frail older adults often find they must interact with healthcare professionals more than usual. These stresses can strain personal and professional relationships and impact quality of care. How can healthcare professionals partner more effectively with family caregivers of frail older adults? Dr. Harvath will describe how to identify a family caregiver, how to assess the caregiver to determine what assistance or support is needed, and how to help them navigate some of the ethical dilemmas they encounter in their family caregiving role.

Healthcare Help for Family Caregivers for Frail Older Adults

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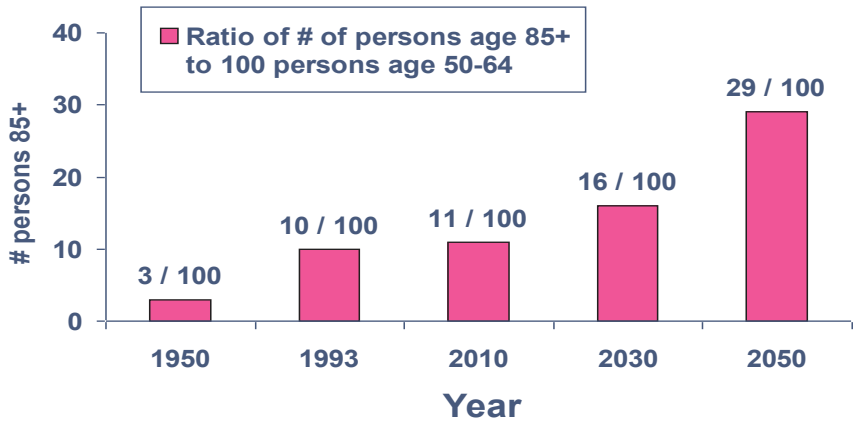
Clinical Professor, School of Nursing

Associate Director for Clinical Science & Practice, Center for Healthy Aging and Innovation

University of Minnesota

Parent Support Ratio



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Projections

- If the family support ratio continues to grow as projected, about half the families in the US will be involved in family care by 2030.

Caregiving by the Numbers

- About 34.2 million Americans have provided unpaid care to an adult age 50 or older in the last 12 months.
- About 15.7 million adult family caregivers care for someone who has Alzheimer's disease or other dementias.

- Cost of unpaid family care: $600 Billion/year (AARP, 2021)

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Identifying Family Caregivers

Based on the Older Person

- Impairment in Instrumental Activities of Daily Living
- Impairment in Activities of Daily Living
- Functional Impairment
- Chronic conditions that require complex medication regimens
- Frail older adults with multiple co-morbid conditions

Based on the Caregiver

- Do you help an older relative because of their advancing age or health problems?
- Do you provide help to someone who can't manage their own needs (e.g., bathing, dressing, medications, health care appointments…).
- Do you check in on an older relative who you kind of worry about?

AARP/NAC Study Major Findings

- Care is intense and complex;
- Caregivers are diverse;
- Social isolation increases risks;
- Caregiving has both positive and negative impacts; and,
- Caregivers still on their own with little preparation.

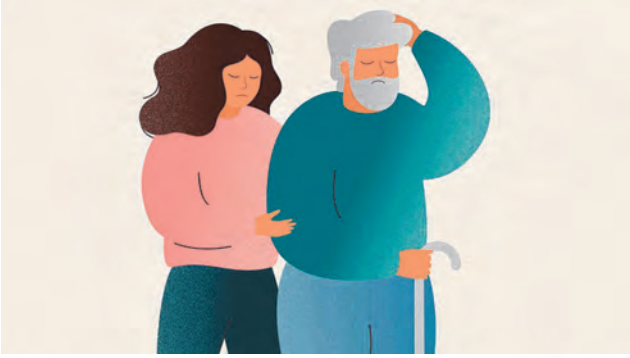
Reinhard et al, (2020)

Negative Consequences for Caregivers

- Mental Health
- Physical Health
- Lifestyle
- Well-Being
- Family Relationships
- Caregiving Stress

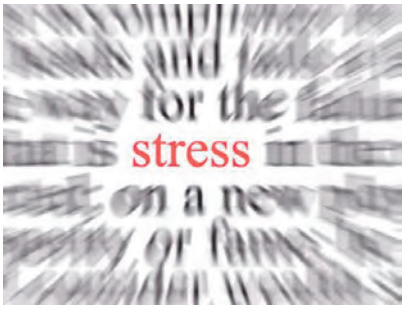
Sources of Caregiver Stress

- Stress from caregiving activities
- Stress from behavioral symptoms
- Strain from feeling manipulated
- Global strain
- Stress in the relationship
- Negative lifestyle changes
- Strain from worry



Correlates of Increased Stress

- Illness Severity
- Suddenness of Onset
- Amount of Change of Patient Status
- Demographic Factors
- Pre-existing Psychological Problems
- Pre-existing Physical Problems
- Concurrent Stressors



Correlates of Decreased Stress

- Mutuality
- Preparedness
- Rewards
- Informal Support
- Formal Support
- Other Interventions

Interventions to Improve Family Care: Meta-analysis

- Psycho-educational
  - Individual
  - Group
- Respite
- Support groups
- In-home interdisciplinary ser

Family Caregiving Institute

- Consultative services include:
  - Online tools
  - Family support groups
  - Caregiver trainings
  - Decisional Support for Caregiving Dilemmas
- Provided family caregiving services, including assessment of caregiver stress and preparedness
- Did not provide direct caregiving to older adults

Difficult Decisions in Caregiving

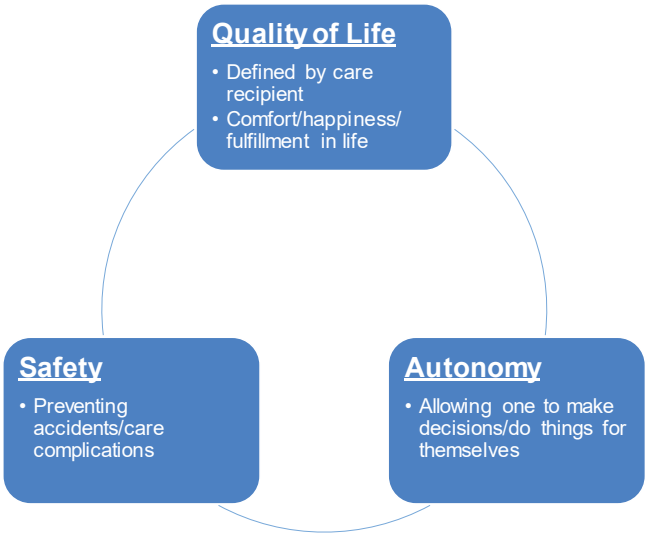
- People think of:
  - End of life care
  - Code status
  - Invasive medical interventions, etc.

- Reality: many difficult decisions
  - Can my family member:
    - Be left alone?
    - Manage their medications themselves?
    - Continue to drive?
    - Cook for themselves?
    - Stay in their home? Do they need a higher level of care?
  - As a caregiver,
    - Can I assist my family member with personal care tasks (toileting, bathing, etc.)?
    - How do I balance my own responsibilities with my family member's needs?
    - Do I take time off work to care for my family member?
    - How do I manage caring for a family member I have a complicated relationship with?

Safety and Autonomy: Often at Odds

- Safety
  - Often prioritized in healthcare over autonomy
  - Can feel like top priority because it mitigates risk
  - Maximizing safety may mean not having a loved-one do many activities to prevent falls, injury, medication error, infection, etc.
- Autonomy
  - Often sacrificed to maximize safety
  - Often important to care recipients and their quality of life
  - Prioritizing this may require a caregiver to assume some risk on behalf of their loved one and in service to their loved one

Care Priorities at Play: A Three-Legged Stool



Example: Do I have to move Dad to memory care?

The Three-Legged Stool

- Safety:
  - YES: increased trained medical care, special equipment and care protocols
  - NO: falls still happen, infections still happen, COVID still happens
- Autonomy:
  - YES: ...in some ways – choosing activities, etc.
  - NO: lots of care/daily tasks done by others
- Quality of Life:
  - ...depends on how care recipient/caregiver define quality of life
  - ...depends on facility

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Changes in Caregiving over Time

- The problems caregivers deal with today are likely to change.

Warning Signs

- Relative's condition worsens, despite best efforts.
- No matter what they do, it isn't enough.
- They feel as if you're the only one in the world experiencing this.
- They don't have a place/time to be alone.

Warning Signs *(cont.)*

- Caregiving significantly interferes with work.
- Feeling it is selfish to think of their own needs.
- Their coping methods are destructive.
- There are no more happy times.

Always remember:

- Caregivers should put on their own oxygen mask first before helping others!

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Thank you!

Questions?