ECHO Idaho: Alzheimer's Disease and Related Dementias
CASE RECOMMENDATION FORM

ECHO Session Date: 5-5-26

Thank you for presenting your patient at ECHO Idaho –Alzheimer's Disease and Related Dementias session.

Summary:
The patient is a 74-year-old unhoused male with no current medications and a history of alcohol use who demonstrated progressively worsening cognitive impairment and behavioral concerns. Initially, while at the previous shelter, staff observed early memory loss and confusion, but he declined assessment. After moving into the new shelter, his symptoms escalated significantly: he was unable to remember where his bed was, repeatedly believed each day was his first, wandered the halls at night, struggled with hygiene, frequently left the property to drink, and at one point became so disoriented that he returned to the former, now-closed shelter, requiring outreach assistance to locate him safely. Over time, his behaviors intensified to include aggression and racially inappropriate language, causing distress and safety concerns for both staff and guests. A medical visit for persistent itching revealed severe scabies, likely related to his inability to maintain basic self-care. Due to increasing concerns for his safety and the wellbeing of others, he was transported to the hospital for protective placement and comprehensive evaluation.

Key Questions:

- How can we recognize when behaviors are more likely related to dementia rather than mental health or substance use, and what are the best ways to respond early to confusion, wandering, and escalating agitation to keep everyone safe?
- When someone is refusing care, hygiene, or assessment, how do we determine when to push for medical evaluation or protective placement, and what steps and documentation support those decisions?
- How do we balance meeting the needs of individuals with advanced cognitive decline with the safety and wellbeing of the broader shelter community, and what training and emotional supports do frontline staff need to do this work sustainably?

You and your team are doing tremendous, thoughtful work under very challenging conditions and providing compassionate support. Thank you.

After reviewing the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Medical & Diagnostic Care

- Prioritize evaluation for reversible causes of cognitive impairment, confusion, and delirium as there are several potential reversible causes; addressing even one could significantly change the trajectory.

- Ensure treatment of acute medical contributors (e.g., scabies), recognizing that something like scabies alone can send any person into severe agitation and delirium.
- Consider the role of alcohol use as a contributing or compounding factor in confusion, behavioral escalation, and delirium.
- Use neurocognitive placement holds when appropriate to allow stabilization, address acute medical issues, and reach a calm enough state for a meaningful assessment.
- Pursue neurocognitive assessment once stabilized to clarify the underlying diagnosis and establish a baseline for ongoing treatment.
- Expand access to on-site medical care, including regular physician presence, house calls, and telehealth visits, in coordination with existing providers.
- Assess for veteran status and family/community supports early; if an individual is a veteran, VA outreach staff may assist with enrollment and eligibility for expanded services.

Shelter Environment & Structure

- The panel is pleased that your shelter offers the following which can help reduce environmental stressors:
  - Smaller dorms or pods instead of large congregate spaces
  - Control over lighting and temperature
  - Fewer daily transitions (e.g., no requirement to leave during the day)
- Design trauma-informed spaces that are less overwhelming and reduce antagonistic moments such as constant bumping into others.
- Create quieter, lower-stimulation areas for individuals who are more vulnerable to agitation or unpredictability in others.
- Incorporate sensory-supportive environments, recognizing the importance of "sensory, sensory, sensory," including calming music, access to nature, soothing beverages (e.g., herbal teas), and comforting scents or textures (lavender lotion).

Staff Training & Support

- Connect staff to community training resources, such as:
  - Dementia care and improvisation-based de-escalation programs (e.g., Aging Strong).
  - Evidence-based approaches like *Bathing Without a Battle* to reduce distress during hygiene care.
- Normalize that this is not a problem the shelter can solve alone and remove unrealistic pressure from staff to "fix" complex neurodegenerative and medical conditions within shelter walls.
- Continue to use neutral language, calm approaches, and trauma-informed responses, especially during moments of escalation.
- Provide emotional support for staff, acknowledging the moral distress and burnout that can arise when guests are declining and resources are limited.

Occupational Therapy & Functional Support

- Utilize OT for functional cognitive assessment, particularly when formal testing is not tolerated; functional tasks often yield better engagement and adherence.
- Use OT input to clarify:
  - Cognitive level
  - Appropriate cueing strategies
  - Needed routines and environmental structure
- Establish consistent routines and leverage familiarity, recognizing that routine is, very helpful.

- Apply OT strategies to hygiene and activities of daily living, acknowledging impaired time perception (e.g., genuinely believing they already showered).
- Emphasize care approaches that reduce confrontation, especially during personal care.

Engagement, Purpose & Daily Structure

- Offer simple, purposeful activities to help individuals stay contained, moving, and focused, such as folding items, gentle walking routines, checking small tasks, or caring for plants or animals (e.g., feeding squirrels).
- Focus on engagement rather than correction, avoiding arguments around perception or memory

Peer & Buddy Supports

- Continue and expand shelter buddy or peer-to-peer programs, pairing individuals who enjoy helping others with those needing extra guidance.
- Recognize that staff can't be everywhere, and peer supports can reduce isolation, confusion, and wandering.
- Explore training residents with natural caregiving strengths, including caregiving courses or certifications, to support others within the shelter.
- Consider partnerships with Area Agency on Aging programs to support aging guests and connect to caregiver resources.

Safety, Boundaries & Escalation Pathways

- Continue to balance care with safety, acknowledging that behaviors such as aggression, racial slurs, or sexualized language impact both guests and staff.
- Establish clear thresholds for hospital transfer or higher-level care when safety risks escalate.
- Maintain strong hospital partnerships to ensure concerns are heard and guests are not discharged back without adequate supports.
- Explore practical identification and tracking strategies to reduce wandering risk, even if high-tech options are not feasible.
- Recognize wandering and repeated disorientation as medical red flags, not just behavioral challenges.

System-Level Planning, Documentation & Future Readiness

- Document everything consistently and thoroughly—behavior changes, refusals of care, and safety risks—to support medical decisions, protective placements, and continuity of care.
- Continue strengthening cross-sector partnerships (healthcare, VA, AAA, aging services, education, and housing) to better support older adults with cognitive decline experiencing homelessness.