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UTHealth
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Medicine

Training on Latinos with Dementia

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UTRio Grande Valley

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Dementia in
Latinos

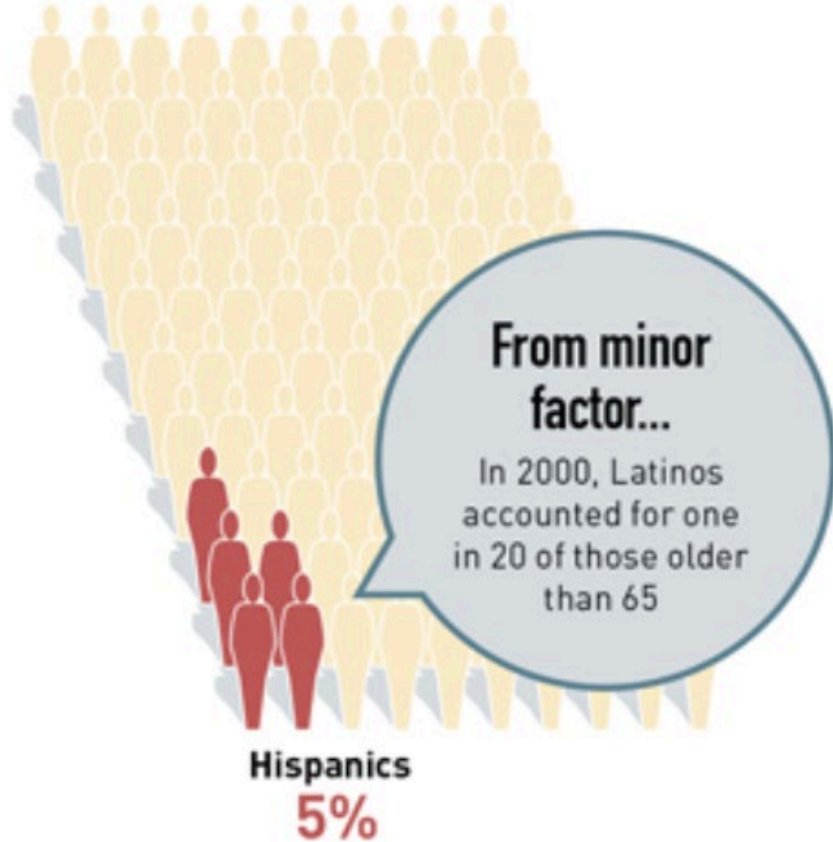
Training the
Workforce

Traning on
dementia

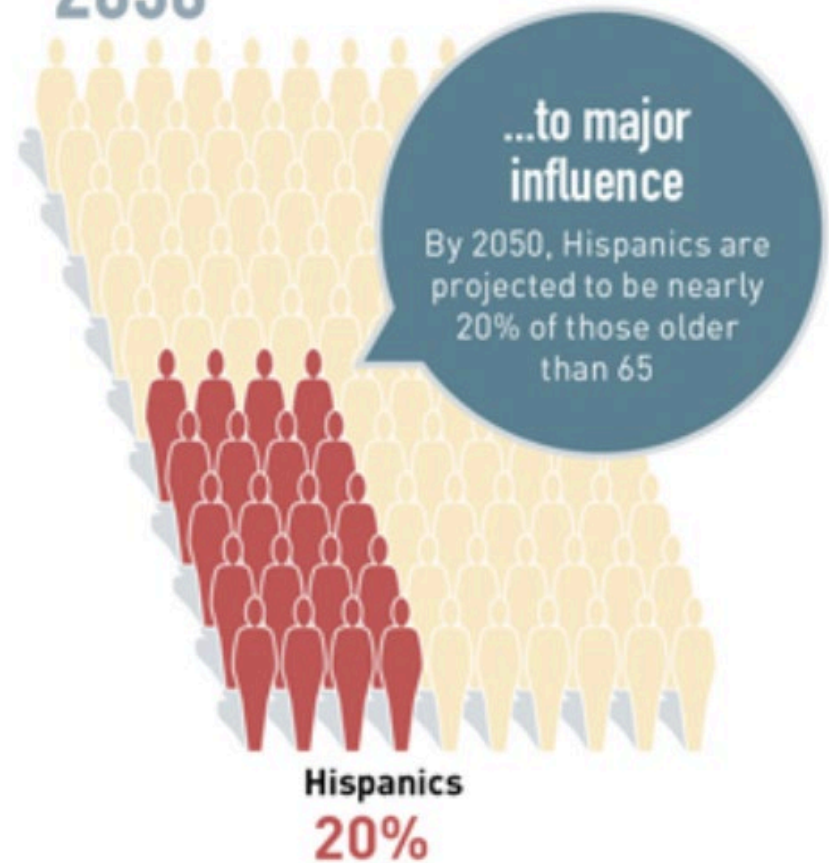
Latino
Experience

ADRD in Hispanics

2000



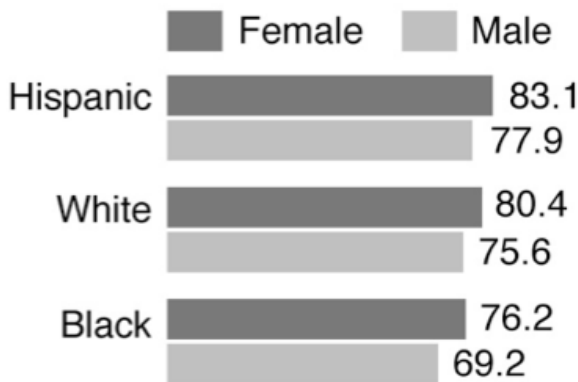
2050



Latino longevity

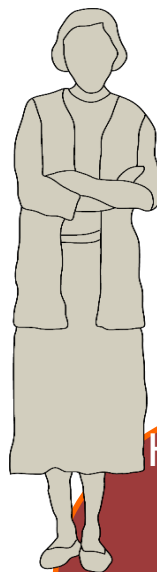
Hispanics born in 2006 can expect to live longer than their black and white counterparts in the U.S.

U.S. life expectancies, 2006



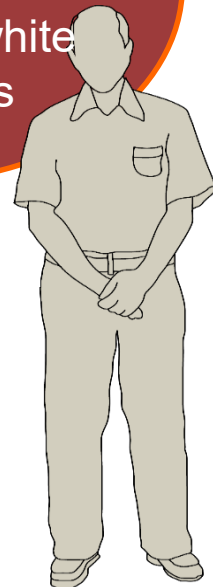
SOURCE: Centers for Disease Control and Prevention

AP

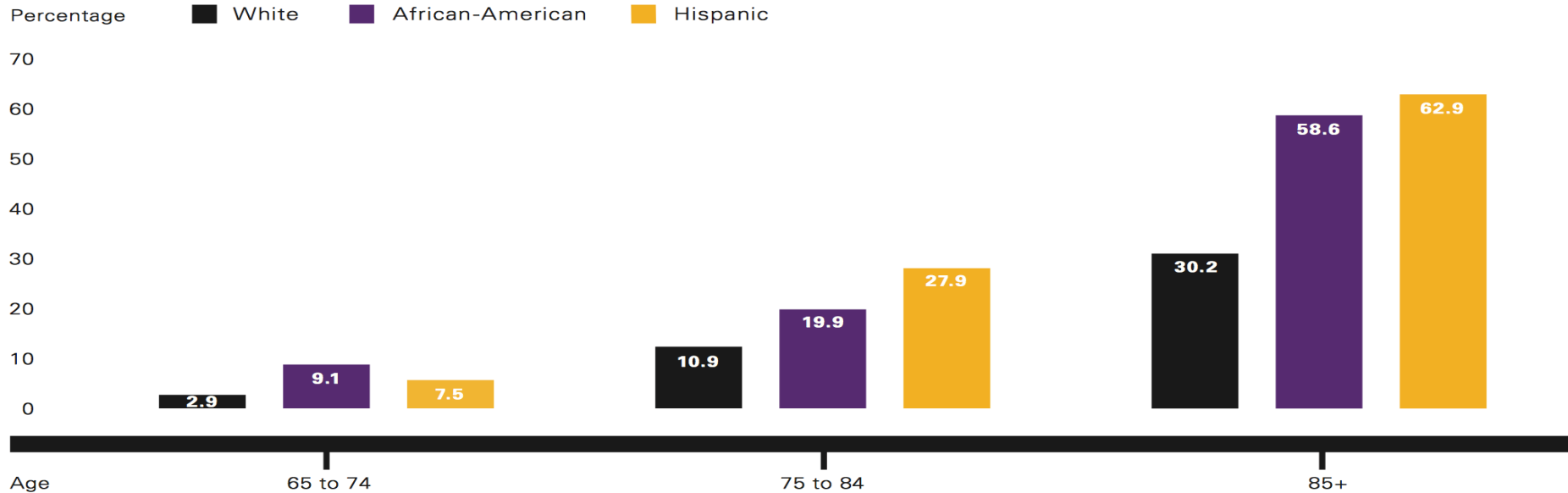


Hispanics suffer a **64% higher incidence of diabetes** than non-Hispanics white Americans

Alzheimer's disease symptoms begin **7 years earlier** in Latinos than in non-Latino white americans

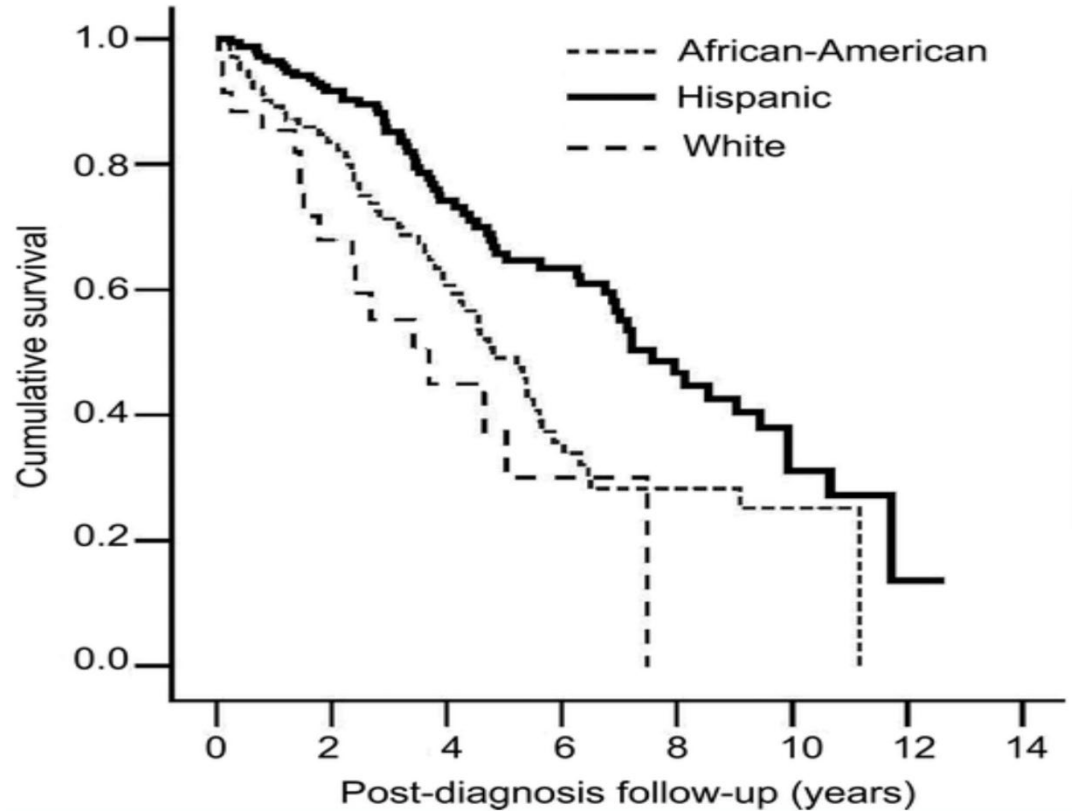


Alzheimer's disease and other dementias, by race/ethnicity, Washington Heights-Inwood Columbia



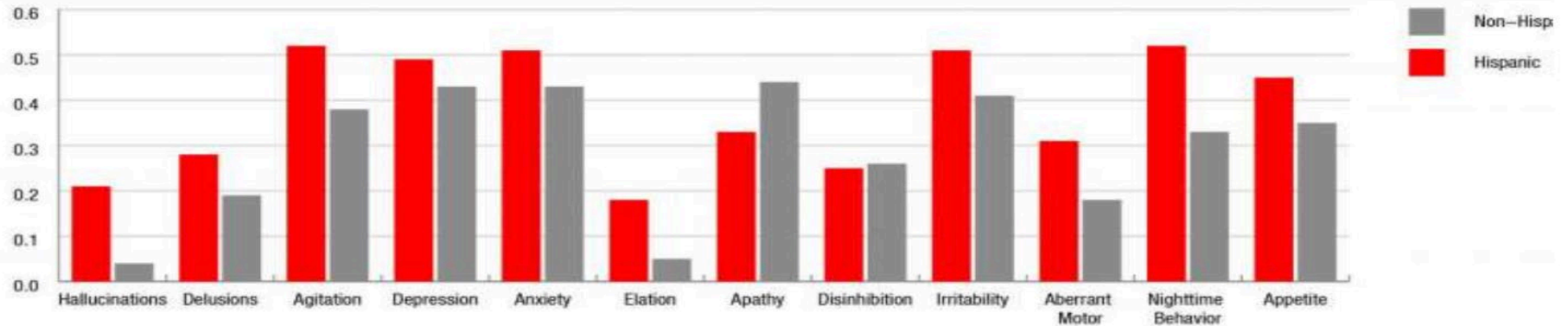
https://www.alz.org/downloads/Facts_Figures_2011.pdf Gurland et. al, 2006

Postdiagnosis survival of Alzheimer's disease by race/ethnic group



Source:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2843528/>
Helzner et al., 2008



COMPARISON OF HISPANIC AND NON-HISPANIC BEHAVIORAL SYMPTOMS WITH ALZHEIMER'S

Comparison of Hispanic and non-Hispanic behavioral symptoms with Alzheimer's disease. Credit: Texas Tech University Health Sciences Center El Paso

Source: <https://medicalxpress.com/news/2016-10-alzheimer-manifests-differently-hispanics.html>. Salazar et. Al. 2016

Dementia in
Latinos

Training the
Workforce

Growing mismatch between the current and those skills needed:

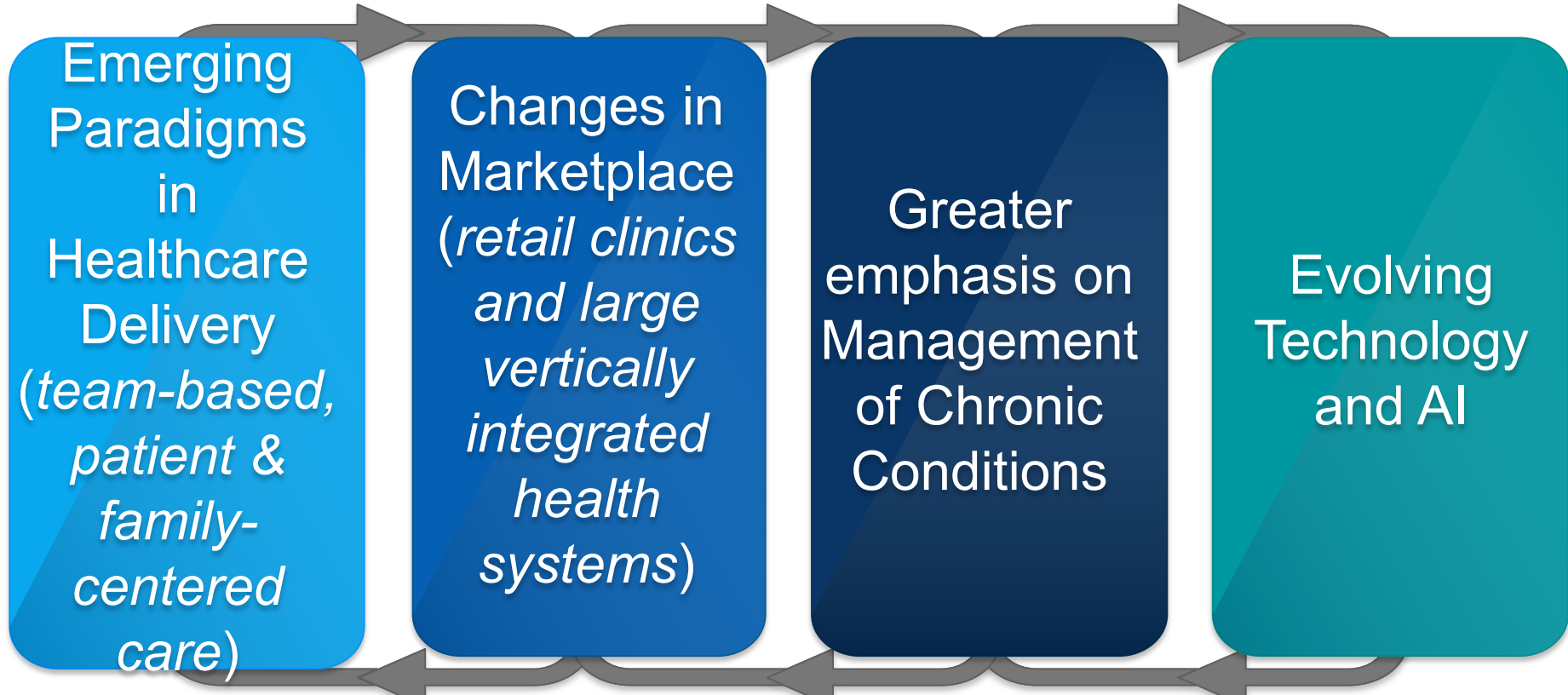
Emergent paradigms for healthcare delivery, such as team-based care and patient and family-centered care

New entrants into the healthcare marketplace, such as retail clinics and large vertically integrated health systems

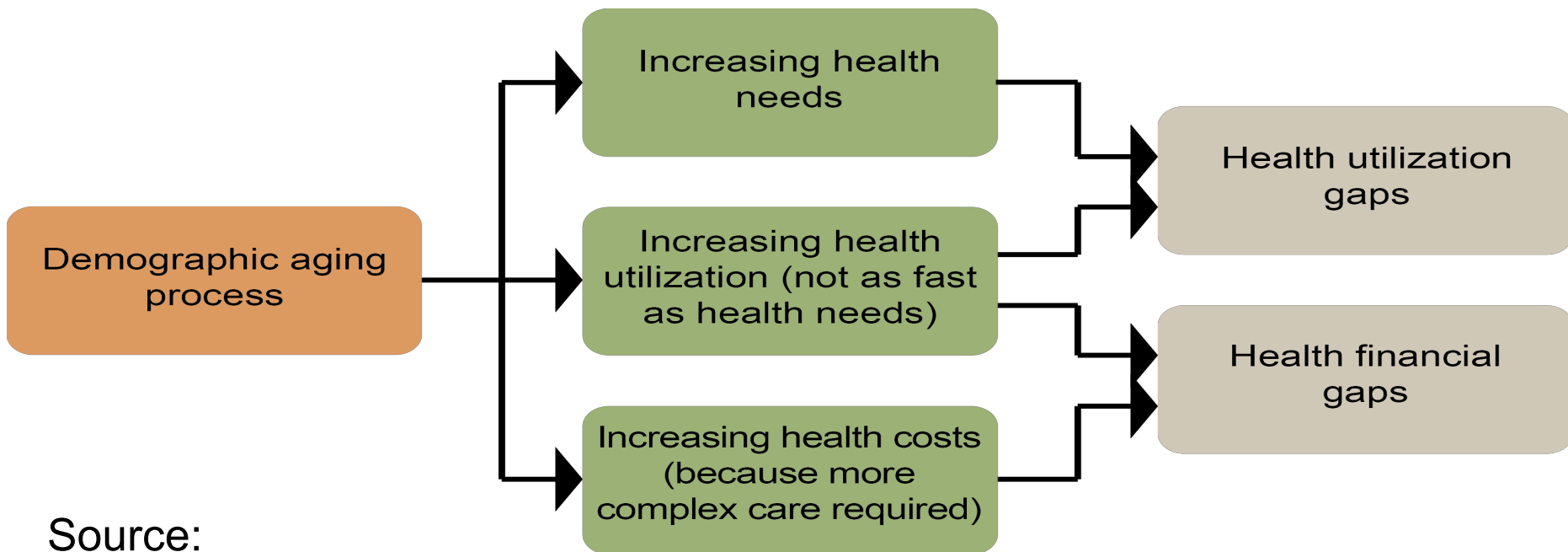
Greater emphasis and responsibility for management of chronic conditions and population health

Rapidly evolving healthcare technologies that will significantly alter the traditional role of many health professional and increase/decrease the demand for others

Growing mismatch current vs. needed skills



Aging and Health Demands



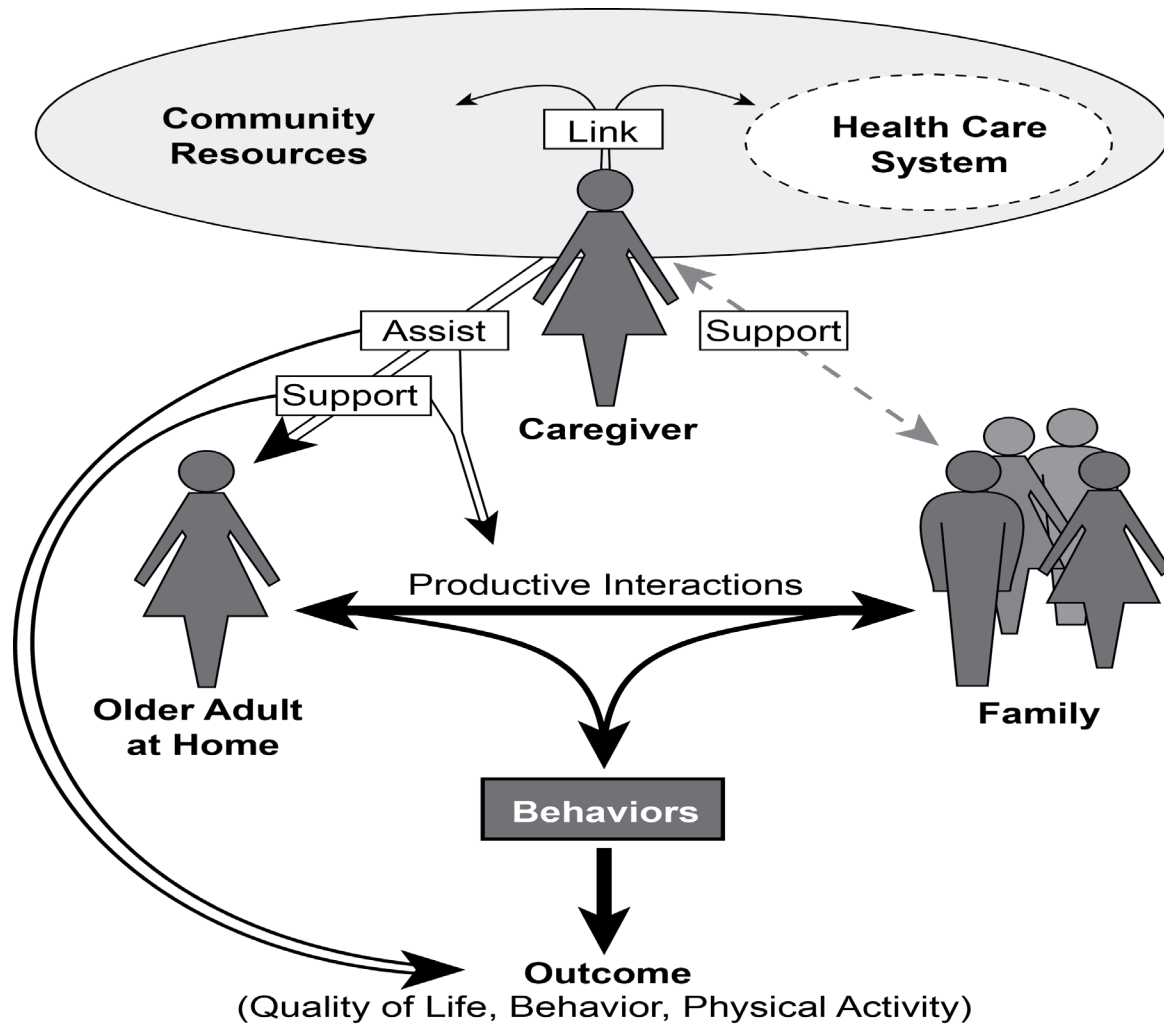
Source:

The World Bank, 2011



Dementia is the primary
cause of disability in elderly

Psychosocial needs are
overwhelming



Competencies

Professional

Cognitive



Psycho-motor



Affective



Ethical



Non- Professional

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Dementia training and educational delivery

A. Small/large group face-to-face

69 (45)

B. Small/large group face-to-faces plus

51 (34)

In-service/practice-based learning 25
(16)

Mentorship/supervision 6 (4)

Experiential learning/simulation 7 (5)

Practical exercise/project 5 (3)

Written materials 3 (2)

Psychoeducation 1 (1)

Online learning 1 (1)

DVD 1 (1)

Drama 1 (1)

Peer support

C. Other

Individual/group DVD 9 (6)

Written resource 6 (4)

Online 5 (3)

In-service 4 (3)

Train-the-trainer 3 (2)

Peer support/learning set 2 (1)

Simulation/experiential 2 (1)

Drama 2 (1)

Counselling 2 (1)

Psychoeducation

Surr et al (2017) Rev Educ Res 87(5): 966–1002

The Kirkpatrick model for evaluation of training

Level 1: Reaction

To what degree participants react favorably to the learning event

Level 2: Learning

To what degree participants acquire the intended knowledge, skills and attitudes based on their participation in the learning event

Level 3: Behavior

To what degree participants apply what they learned during training when they are back on the job

Level 4: Results

To what degree targeted outcomes occur, as a result of the learning event(s) and subsequent reinforcement

Kirkpatrick D. L. (1984). Training and Development J, 32(9), 6–9

Level 1: Reaction

To what degree participants react favorably to the learning event

How: Informal discussions and semi-structured interviews to questionnaires with open or fixed-response questions.

What:

- Perceived applicability in role and practice
- Delivery method preferred: Interactive group work
- Higher quality training materials (clear, easy to follow, concise)
- Skilled trainer/facilitator

Surr et al (2017) Rev Educ Res 87(5): 966–1002

Level 2: Learning

To what degree participants acquire the intended knowledge, skills and attitudes based on their participation in the learning event

How: Validated measures, non-validated questionnaires, surveys or scales, interviews, focus groups, and analysis of written assessments, self report.

What: - **Knowledge/Skills:** In-service learning alone less effective than either face-to-face alone or in combination with face-to-face delivery. Written resource (online or hard copy) is the weakest.

- Meaning-making, reflection, and learner debriefing and feedback.

- **Attitudes** change needs consolidated time (sessions +2h).

- **Confidence, Competency & Self-efficacy** better with (5): 966–1002

interactive and combination of theory and practice.

Level 3: Behavior

To what degree participants apply what they learned during training when they are back on the job

How: Review of care records (40%), observations of staff behaviors & practice (27%) and staff self report (40%).

What: - **Areas of change:** Communication, antipsychotic prescribing and administration, person-centered care/general care practice improvements, restraint implementation of a specific care process or tool.

- Teaching included structured application of learning into practice.

- **Rewarding Approaches:** in-practice activities or projects to be implemented; expert clinical supervision; application of a participatory action research cycle; provision of tools or decision support software; developments of Champions that support implementation.

Stratton et al (2017) Rev Educ Res 87(5): 966–1002

Level 4: Results

To what degree targeted outcomes occur, as a result of the learning event(s) and subsequent reinforcement

How: Mixed methods(10%), qualitative (8%) and quantitative staff (82%).

What: - **Outcomes for people with dementia:** Agitation, anxiety and aggression, quality of life, depression, communication and activities of daily living. Situated learning, in-service mentoring and facilitation by expert clinician.

- **Outcomes for family members:** Satisfaction with care of their relative. Inconclusive due to low number of studies.

- **Outcomes for staff:** 1) Job satisfaction & accomplishment (44%); stress, strain and burden (56%); exhaustion, burnout and health complaints (38%). Deeper staff engagement (longer sessions and longer training), related to change in attitudes and available tool decision or manual

Summary of evidence of dementia training most likely to be



- 1.- Relevant and realistic to the role, experience, and practice of learners no a one-size-fits-all
- 2.- Includes active participation
- 3.- Underpins practice-based learning with theoretical or knowledge-based content
- 4.- Ensures experiential and simulation-based learning includes adequate time for debriefing and discussion
- 5.- Experienced trainer/facilitator
- 6.- Does not involve reading written materials (paper or Web-based) or in-service learning as the sole teaching method
- 7.- Total duration of 8+ hours with individual training sessions of at least 90 minutes
- 8.- Includes active, small, or large group face-to-face learning either alone or in addition to another learning approach

Surr et al (2017) Rev Educ Res 87(5): 966–1002

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Experience



Focus on Latinos!
Los amo



Active coping
Planning
Instrumental support
Positive reframing
Humor
Religion
Self-distraction
Venting
Emotional support



**Coping Strategies &
Goal Reengagement**

Curriculum

- Basic needs: Hygiene, comfort, mobility, sleep, safety, nutrition.
- Familial and social interventions.
- Cognitive and physical stimulation.
- Management of difficult situations.
- Well being of caregivers.



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Unleashing our inner Frida in Brownsville!





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