TAKING CARE OF PATIENTS

DEMENTIAVILLE OR DE HOGEWYEK:
A PIONEERING CARE FACILITY FOR ELDERLY PEOPLE WITH DEMENTIA

De Hogeweyk is a model village for elderly people with dementia setting in Weesp, The Netherlands.

It is a pioneering care facility for elderly people with dementia.1 Carers, doctors and nurses work around the 152 residents to provide the 24-hour care necessary to allow the residents with dementia a more active lifestyle. The ambitious experiment began 20 years ago amid controversy and strong opposition from critics who questioned the wisdom of allowing dementia patients to live without locks, with minimal medication, in their own homes, doing the same things they loved before illness took hold. Yvonne van Amerongen, one of the six founders, explains the idea. "It was 1992 and De Hogeweyk was being run as an ordinary care home: wards, common rooms where 20 people sat watching TV, doing nothing, waiting for medication, for meals", she says. "It wasn't living. It was kind of dying."1

A brain storming process began and by early 1993 they had the answer. Yvonne says: "In life, we want to live with people like ourselves. We want to be surrounded by people we would choose to be friends with."1

The result was a village with several lifestyle options, e.g. a town square, supermarket, hairdressing salon, theatre, pub, café-restaurant — as well as the twenty-three houses themselves. Each house reflects a different style that is common to the six or seven people which live in that house.1 The seven settings provided are Stads, for those used to living in an urban city area, Goosie, with an aristocratic Dutch feel, Ambachtelijke used to working as trades people or craftsmen/ women, Indische for those with an association with Indonesia and the former Dutch East Indies, Huiselijke for homemakers, Culturele for those brought up with theatre and cinema, and Christelijke for those with a central religious aspect to life, whether Christian or another religion.1

Residents do the necessary shopping at the supermarket and assist with preparing and cooking as they would at home.2 The carers wear normal daytime clothing and fit into a role that the dementia sufferers are likely to be comfortable with. The different living styles have different types of music playing, significantly varied interior design, food and methods of table setting.3 Residents within each house have their own large bedroom and then meet with other residents to share the living room, kitchen and dining room.3 There are no locks on the doors and residents are free to mix and walk or cycle around within the village.3

There are around 250 staff members. In order to maintain the "fake reality" that those living at De Hogeweyk are comfortable with, the staff do not seek to correct the residents as the residents are talking about memories, background and history.3 At the same time, the staff will not deceive the patients if directly asked, truthfully stating that the residents are in a place where they can receive required care for their condition.2 Because of the nature of Alzheimer disease and dementia, the sufferers remember the distant past, rather than the present, so even truthful answers given by the staff will get forgotten quickly.2

On a physical level, residents at De Hogeweyk require fewer medications; they eat better, and yes, they live longer. On a mental level, they also seem to have more joy.

References:

Links:
http://en.wikipedia.org/wiki/Hogewey
http://en.wikipedia.org/wiki/Hogewey

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WHAT’S NEW
New blood test for the diagnosis of AD

HAVE YOU HEARD…
…about the G8 dementia summit?

DEMENTIAVILLE
A new nursing home concept in the Netherlands
HAVE YOU HEARD…

G8* – GLOBAL ACTION AGAINST DEMENTIA

The G8 dementia summit, held in London in December 2013, brought together ministers, researchers, pharmaceutical companies and charities from around the world.

Dementia was identified as a major disease burden. It is a condition that impairs the cognitive brain function of memory, language, perception and thought and which interferes significantly with the ability to maintain the activities of daily living. Dementia affects more than 35 million people worldwide and this number is expected to almost double every 20 years.

Seventy per cent of the estimated annual world-wide cost of US$604 billion is spent on informal, social and direct medical care. Yet nearly 60 per cent of people with dementia live in low and middle income countries so the economic challenge will intensify as life expectancy increases across the globe. These costs are expected to increase significantly if therapies to prevent and treat dementia are not developed and implemented. Investment at a global level is needed.

The aim is to identify a cure or a disease-modifying therapy for dementia by 2025 and to increase the amount of funding for dementia research to reach the goal. The need to increase the spending on dementia research is in focus.

There is a need for innovation to improve the quality of life for people with dementia and their carers while reducing the emotional and financial burden. A priority is to make timely diagnosis and early intervention feasible, affordable and cost effective. Merz has contributed to easier monitoring by the development of the ROSA scale. (Holthoff, Ferris et al. 2011, Holthoff, Ferris et al. 2012). Furthermore care homes should be more responsive to the needs of the patients. Additionally a better understanding of risk factors for dementia and the option to reduce the risk is a focus. Together with Professor Miia Kivipelto, who also participated in the G8 dementia summit, Merz has developed a free-of-charge mid-life risk factor app to help physicians discuss and visualize the effect of preventive measures. The CAIDE Risk Score App is important and unique in detecting the risk to develop dementia through the use of an evidence-based tool. (Poster Sindi, Springfield, March 2014).

Dementia requires long term health and social care support. Providing care for those with dementia can present challenges for families and carers. Better and more concrete measures for improving services and support of people with dementia and their carers is needed to improve their quality of life and wellbeing. Individually tailored care, ambulant living options; affordable options for care and everyday support are needed. One great example for individual care is Dementiaville De Hogeweyk in Holland.

Carers are often older adults, mainly women, who may be dealing with their own health problems, therefore a need for information of carers is obvious, including how to deal with dementia related behaviors, and access to support in acute situations and crises. Reduction of stigma and fear is another important topic. Negative reactions from family, friends, professionals, and the society as a whole may prevent people from seeking assistance. It is necessary to treat affected people with dignity and respect.

References:
http://dementiachallenge.dh.gov.uk/

*G8 = Group of Eight (G8) is a forum for the governments of eight of the world’s largest national economies. The countries are Canada, France, Germany, Italy, Japan, Russia, United Kingdom, and United States of America.

G8 dementia summit, held in London in December 2013, brought together ministers, researchers, pharmaceutical companies and charities from around the world.
A MEMANTINE TABLET DOES NOT ALWAYS LOOK LIKE … A MEMANTINE TABLET.

“Patients rely on the color, size, and shape of medication for reassurance that they are taking the right pill.” Furthermore generics are marketed under different names and in different package sizes. The variety of differently looking pills and packages is enormous when it comes to generic products. Every product has its own name and exclusive design. Variations in any one of these factors can be confusing for AD patients and their carers. In combination the lack of transparency becomes overwhelming.

One more aspect which is important to know is the bioequivalence range. The accepted range is minus 20% to plus 25% of the reference product (80% - 125%). That means “If a generic drug is deemed to be bioequivalent and has the same active ingredient as the branded drug (...) the drug is approved as therapeutically equivalent.” That means that a patient who has reached the maintenance dose on a generic product in the low end theoretically can shift from 16 mg to 25 mg when the manufacturer is changed. For a product that is up-titrated with 5 mg increments, this is hardly appropriate.

Cost savings by the means of generic substitution may not be optimal for cognitively impaired patients with elderly carers.

Let’s look at an example; a patient is taking five medicines a day, each can be provided by five generic manufactures. That means the patient faces over 3000 possible combinations of pill appearances in the pillbox. For some patients these changes could be perilous.

Even young hands with no limitations of strength and mobility may have problems breaking these ‘caterpillar’ tablets into four parts for titration.

Furthermore some of the available generic memantine tablets are very impractical for the titration, e.g. a tablet which can be broken in four parts. That geriatric patients have difficulties breaking tablets is known and keeping track of halved and quartered tablets is really complicated from an AD patients’ perspective. This can lead to an interruption of the treatment.

Non-adherence can also be costly from an economic perspective in that a poorly controlled disease may require additional drug therapy or hospitalization for the patient.

References:
1. Engelberg, 2011, The Case for Standardizing the Appearance of Bioequivalent Medications, Journal of Managed Care Pharmacy, Vol. 17, No. 4
6. References:

NEW BLOOD TEST FOR THE DIAGNOSIS OF ALZHEIMER DISEASE

Scientists from the Saar university developed a new blood test for a fast diagnosis of Alzheimer disease (AD). The test could replace the time consuming current differential diagnosis of the different dementia forms. The currently used test are on the one hand expensive like computer tomography or magnetic resonance imaging and on the other hand there are the time consuming psychological tests.

The new blood test is based on biomarkers, in this case on microRNAs. MicroRNAs are small nucleic acids, which are present in the blood of every person. Those MicroRNAs are very important as their composition is specific for each disease. It was tested if such a specific microRNA pattern exists for AD and in a study with 100 AD patients the precision, sensitivity and accuracy was above 90 percent.

Source: Healthcare-Saarland