Master of Public Health

Integrative Learning Experience Report

PROMOTING DEMENTIA-FRIENDLINESS IN MANHATTAN, KANSAS

by

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submitted in partial fulfillment of the requirements for the degree

MASTER OF PUBLIC HEALTH

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Summary/Abstract

As the population of people aged 65 and older has increased by both number and proportion, importance has been placed on shaping communities in which seniors can age in place. “Dementia-friendly communities” are communities in which people living with dementia can navigate public spaces safely and be treated with dignity and respect. The Flint Hills Wellness Coalition launched Dementia Friendly Manhattan in 2021 in response to this community need. I worked with Dementia Friendly Manhattan to develop a training curriculum that would be given to any business employees that work with the public. Specifically, businesses that provide essential services such as grocery stores or banks will be targeted. The curriculum focused on dementia awareness, education, signs, and communication strategies. The goal of the training was to make local businesses dementia-friendly and give employees the tools they need to assist customers with dementia. In order to evaluate the effectiveness of this program, I developed a pre- and post-training survey to be administered to trainees. Businesses who participated in the training would receive a certificate of completion that could be displayed at their establishment, as well as a window cling that could be placed in the door or window of their establishment. By creating a recognizable window cling, people living with dementia would be able to easier recognize where they could get help if they need assistance, as well as experience an elevated sense of welcomeness in the community. Additionally, the recognizability of the window cling would encourage other establishments to seek dementia-friendly training so that they could also receive the recognition of being dementia-friendly. This project focused on the social aspect of dementia-friendliness within the community and was meant to improve the quality of life for people living with dementia in Manhattan.

Subject Keywords:

Dementia, aging in place, community, dementia-friendly, Dementia Friendly Manhattan

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Chapter 1 - Literature Review

"Population aging" refers to the phenomenon in which an increasingly larger proportion of the population is 65 years of age or older (WHO, 2010). In 1920, one in 20 Americans were 65 or older. By 2020, this proportion had grown to one in six Americans (Caplan, 2023). Population aging can largely be attributed to increased life expectancy and decreased fertility rates (WHO, 2010). Accordingly, there has been an increase in the prevalence of dementia worldwide. In 2020, an estimated 55 million people were living with dementia. By 2030, this number is projected to reach 78 million (ADI, n.d.). The World Health Organization (WHO) identified dementia as a public health priority, releasing the Global action plan on the public health response to dementia 2017-2025 (WHO, 2017). Action area two of this action plan focused on dementia awareness and friendliness. The Global action plan promoted dementia-awareness programs for providing accurate information about dementia, reducing stigmatization, and increasing the public's ability to recognize signs and symptoms of dementia. Additionally, Action area 2 encouraged the creation of dementia-friendly communities that are inclusive and accessible to people with dementia. The increased social inclusion derived from making communities dementia-friendly promotes better health outcomes and better overall quality of life for both people with dementia and their caregivers (WHO, 2017).

In 2013, Minnesota launched their initiative ACT on Alzheimer's. Their mission was to equip communities with the tools needed to support people living with dementia and their caregivers in order to lessen the impact of Alzheimer's disease and other types of dementia (ACT on Alzheimer's, n.d.). The term Action Communities was used to describe the communities in Minnesota that utilized ACT on Alzheimer's resources such as their Dementia Friendly Communities Toolkit. The resources used a whole community approach, involving all sectors of the community including governmental services, public spaces, business environments, faith communities, and healthcare systems (ACT on Alzheimer's, n.d.)

During the 2015 White House Conference on Aging, the Collective Action Lab announced their initiative Dementia Friendly America in response to the success of Minnesota's ACT on Alzheimer's initiative (White House Conference on Aging, 2015). Today, over 300 communities across the United States have joined Dementia Friendly America (USAging, n.d.).

In 2020, Anna Biggins, who was then a student in the Kansas State University Master of Public Health program, conducted a community needs assessment by administering a survey to Riley County residents. She found that while 78% of respondents had personal experience with

someone with dementia, only 17% of respondents were familiar with the concept of dementia-friendly communities (Biggins, 2022). Upon reading a description of the goals of dementia-friendly communities, 86.53% of respondents were in favor of Manhattan, KS becoming a dementia-friendly community. Anna reported these results to the Flint Hills Wellness Coalition (FHWC) and assisted the FHWC in launching Dementia Friendly Manhattan in 2021, making Manhattan the first member of Dementia Friendly America in Kansas.

My project was based on assisting the FHWC with the Dementia Friendly Manhattan initiative as they take the next steps towards promoting dementia-friendliness in Manhattan. Debbie Nuss, who currently serves as the FHWC chair, acted as my mentor for this project. Debbie has worked for over 30 years in management and nonprofit administration. She has experience in the fields of community development, mental health, and services for older adults. Debbie is a part-time coordinator for the Blue Cross Blue Shield of Kansas Pathways to a Healthy Kansas grant awarded to the FHWC. As an active community volunteer, Debbie serves as the FHWC chair and coordinates its Flint Hills Community Care Team. She is currently a member of the City of Manhattan Urban Area Planning Board and the Douglass Recreation Center Advisory Board. Since 2013, she has chaired the annual Everybody Counts event. She has served as treasurer of the Manhattan Juneteenth Planning Committee since 2015. Debbie earned her bachelor's and master's degrees from Kansas State University.

Leaving one's home to complete short, routine tasks helps people living with dementia (PLWD) maintain independence and feelings of social inclusion (Li et al., 2021). However, routine tasks become more difficult as dementia progresses. Obstacles include difficulty with wayfinding, excessive noise from traffic, use of new technology such as self-checkout, and difficulty safely crossing the street (Brorsson et al., 2011). As a result, PLWD may avoid leaving the house to complete routine tasks, or they may limit the range in which they complete the tasks (Duggan et al., 2008). Accordingly, PLWD tend to rely heavily on small stores in their neighborhood (Brorsson et al., 2013). In a dementia-friendly community, PLWD are confident about their ability to contribute to their community and feel supported, respected, and understood (Wu et al., 2019). A review of 29 studies about dementia-friendly communities revealed that many researchers and programs focused on the built environment, neglecting to consider the psychosocial environment (Gan et al.,2022). PLWD have expressed concern over stigmatization and lack of public education on dementia (Phinney et al., 2016). Therefore, Dementia Friendly Manhattan's immediate focus was on raising awareness and informing community members about how they can assist PLWD in their community to promote social inclusion.

Chapter 2 - Learning Objectives and Project Description

I worked with Debbie Nuss to develop a training curriculum that would target various business employees who work with the public in Manhattan, KS. The goal of the training was to explain introductory information about dementia, identify signs of dementia, and discuss communication strategies that could be used when interacting with PLWD.

I developed the training curriculum as a PowerPoint with an accompanying script. To evaluate the program, I created a pre- and post- training survey that would be administered to audience members. Other activities included attending DFM meetings, tabling at Everybody Counts, and assisting in organizing a fall kick-off event.

Learning Objectives

- **Catalogue dementia-related training materials from a variety of public health agencies**

We did not want to rely on one source for the content of the presentation, but instead used a variety of sources in order to examine diverse perspectives from different industries. Many sources focused on one type of dementia, and our presentation was focused on all types of dementia. Additionally, we wanted sources that targeted both rural and urban audiences. Resources were gathered from the Alzheimer's Association, Dementia Friendly America, National Association of Emergency Medical Technicians, Johnson County Emergency Services, and Stormont Vail Health.

- **Examine the most current and widely accepted strategies for communicating with PLWD**

Although I had personal experience with dementia, I needed to educate myself on the best strategies to use when interacting with PLWD in a professional setting in order to effectively deliver the presentation. Emphasis was placed on responding to dementia-associated behaviors such as frustration or wandering. Educating myself would allow me to more confidently deliver the presentation and respond to audience questions.

- **Condense materials into a thirty-minute presentation appropriate for the target audience**

I narrowed down which aspects of each resource we wanted to include in the presentation. For example, some of the information in the resources from Johnson County Emergency Services was too clinical to be included, as it mainly applied to helping PLWD during an emergency situation rather than in everyday life. Other materials, such as from the

Alzheimer's Association, were more appropriate for attending to PLWD as a caregiver rather than in a public setting. Caregiver materials focused on identifying cognitive decline, but this was not relevant to our presentation as we were focusing on public and professional interactions that tend to be brief. Additionally, we did not want to encourage the audience to attempt to diagnose others with dementia. Instead, we encouraged the audience to notice signs that may indicate a person could have memory issues and may require extra assistance. I chose the length of the presentation to be thirty-minutes, as this was the shortest amount of time that the necessary information could be conveyed. The main reasons for keeping the presentation short were that businesses will be more likely to agree to participate in the training if the training is short, and the general attention span of people tends to be brief. A thirty-minute presentation will effectively deliver the necessary information, while being respectful of the audience's time and attention span.

- **Design a pre- and post-training survey to evaluate the effectiveness of the training program**

I researched how to develop surveys, as I did not have any previous experience with this. I was cognizant of keeping the survey short and simple to encourage audience participation. Too many questions can cause burnout and may lead to the survey taker answering questions randomly. Having an identical pre- and post- training survey would allow me to analyze how the presentation affected the knowledge and attitude of the audience.

- **Collaborate with other Dementia Friendly Manhattan members to revise the presentation**

I gave the presentation at one of the monthly Dementia Friendly Manhattan meetings in order to give other members an opportunity to provide feedback. I revised the presentation accordingly and emailed the presentation to the members to confirm that everyone approved of the presentation. This gave me valuable experience working with a group to develop a project, public speaking, and receiving constructive criticism.

- **Present the training curriculum to the target audience**

As a future public health professional, educating the public through talks and presentations is crucial. Administering this presentation would help me practice speaking slowly and clearly, and engage my audience.

- **Analyze survey results to identify program strengths and weaknesses**

The survey was designed so that each question corresponded to one or more learning objectives. This would allow me to identify which learning objectives were not adequately covered in the presentation. The survey used a Likert scale, the results of which are best

displayed with a stacked bar chart. The visualization of the data would also allow me to measure the audience's baseline levels of knowledge and attitude.

- **Assist in holding a public event to promote Dementia Friendly Manhattan and the training program**

In order to reach more local businesses, Dementia Friendly Manhattan planned a "kick-off" event to celebrate the two-year anniversary of Dementia Friendly Manhattan and to introduce our training program. I learned about different aspects required to make such an event successful: enticing venue, refreshments, and a clear agenda for the event.

Activities

- **Attendance at monthly DFM meetings**

Attending the meetings allowed me to network with other members and become familiar with the organization. Each month, I gave an update on the progress of the curriculum development.

- **Development of a presentation with accompanying script**

Using the materials gathered from the sources previously listed, I created an oral presentation to teach local business employees how to best interact with PLWD. I focused on making the presentation visually enticing, as well as including interactive components that encouraged audience participation. The accompanying script allowed other DFM members to easily administer the training sessions.

- **Creation of a pre- and post- training survey**

The survey consisted of five statements with Likert scale responses. There was also a place for comments to give the audience an opportunity to provide qualitative feedback.

- **Collaborate with DFM members to revise and refine the training presentation**

Giving the presentation to the DFM members was a good practice run for giving the presentation to business employees in the future. It is important to have input from multiple people when creating a presentation, as they might have a different perspective that you had not thought of. An example of this was that I used the term "triggers" in the presentation, and one of the members of DFM let me know that term is sensitive for her because of mental health issues within her family. For this reason, I changed the term to "situational factors".

- **Represent Dementia Friendly Manhattan at "Everybody Counts"**

I tabled this community event to raise awareness about DFM and inform event attendees about our new training program. We provided flyers with information about DFM as well as

general information about dementia. “Everybody Counts” is intended to connect people in need to community-based resources. This was an ideal opportunity to inform community members about Dementia Friendly Manhattan, as low-income individuals are at an increased risk of dementia and are less likely to receive dementia-associated care such as in-home health assistance. Thus, this population is particularly vulnerable to the socioeconomic effects of having dementia.

- **Design a certificate of completion and window cling**

These products would be given to participating businesses after receiving the training. Businesses could display these products in their establishment to signal to PLWD that the establishment was a safe and welcoming place. Additionally, this initiative was designed to encourage other businesses to pursue dementia-friendly training so that they could also display the window cling.

- **Creation of event flyer**

I created a flyer to advertise our Fall Kick-off event. The flyer featured our guest speaker, Susan H. McFadden, who wrote *Dementia-Friendly Communities: Why We Need Them and How We Can Create Them.*

Chapter 3 - Results

Dementia Friendly Manhattan Training Presentation

The first step of developing the training presentation was gathering resources from which information would be extracted. I found that most training materials were internal resources and could not be publicly accessed. Fortunately, there were members of DFM who had connections to other organizations with training materials. Prisca Asaro is a member of both DFM and Alzheimer's Association. She was able to provide me with a large amount of internal training resources. The most useful information from these resources were the ten warning signs of Alzheimer's and a wide variety of scenarios for practicing how to help PLWD. However, this information was focused on Alzheimer's disease, and our organization wanted to include information about all types of dementia. Additionally, much of the information was tailored for caregivers rather than employees working with PLWD in community spaces. Prisca also provided me with a recorded lecture developed by Johnson County emergency services on how to respond to calls associated with PLWD. I found this information to be less applicable to the DFM training presentation, as the information was for responding to emergencies and using clinical practices. Josh Gering, another member of DFM, provided me with lecture slides on geriatric education from the National Association of Emergency Medical Technicians. While it is crucial for emergency medical service personnel to have training on interacting with dementia patients, much of the information was not relevant for our purposes. Information focused on medical assessment and observing the patient's home environment. For our DFM training, training recipients were expected to call emergency services if any medical intervention was necessary. Some of the most helpful information for the development of this presentation came from Dementia Friendly America's website. This information focused heavily on helping PLWD who may be strangers in community spaces. Examples of spaces in the community where dementia-friendliness is essential include banks, grocery stores, churches, and parks.

After collecting resources, I developed a list of learning objectives, outlined the presentation, and created the presentation with a script for other DFM members to easily be able to deliver the presentation. I decided to use a PowerPoint presentation accompanied by an oral speech. Taking inspiration from DFA's training materials, I wrote a script so that other DFM members would be able to easily give the presentation. The information written on the presentation slides was kept to a minimum. The presentation slides were used to create visual interest, maintain the audience's attention, and help the audience follow along with the

presentation structure. Most of the information in the presentation was delivered orally, but was supplemented with a paper handout. I incorporated a set of true or false questions, which would engage the audience by encouraging them to raise their hands accordingly when I asked if the given statement was true or false. Audience participation would also be encouraged at the end of the presentation when real-world scenarios were given. Audience members would be asked to share what they would do or say in response to a given scenario.

At our monthly DFM meeting, I presented the training to the other DFM members in attendance. The length of the presentation was about 30 minutes, which we decided was ideal in order to keep the audience's attention. After the presentation, we had time for comments and feedback. From this feedback, I documented specific improvements so that I could make changes to the presentation accordingly:

- Lighten the background on some slides
- Increase the font size on some slides
- Add more pictures for visual interest
- Include dementia statistics for Riley County
- Change "10 warning signs of dementia" to "10 possible indicators of dementia"
- Change "dementia-associated behaviors" to "dementia-associated responses"
- Change "triggers of dementia-associated behaviors" to "possible causes of dementia-associated responses"
- Add an analogy to help audience members understand that dementia is an umbrella term for many types of dementia

DFM members responded positively to the inclusion of photos from around the Manhattan community. I added more local photos as well as more stock photos for aesthetic purposes. One issue was the lack of statistics available for the number of people with all types of dementia. Most statistics focused solely on Alzheimer's disease. We could not find a statistic for the number of people with dementia in Riley County. Therefore, we extrapolated by using the percentage of seniors in the United States living with Alzheimer's and applying this to the population of seniors within Riley County in order to demonstrate to the audience how dementia affects our community (see table 3.1). I created an infographic to better display the dementia figures (see Appendix). Much of the conversation surrounding the editing of the presentation focused on softening the language used. DFM members preferred to use "10 possible indicators of dementia" rather than "10 warning signs of dementia". The use of this language emphasizes that we are not encouraging audience members to diagnose others with dementia, but rather recognize signs that a person may need assistance. The use of the word "behaviors" elicited a

negative connotation and was perhaps overly clinical. We substituted this word with “responses” or “reactions” when speaking about situational factors that may cause a person to display dementia-associated behavior in order to avoid the pathologization of PLWD. One DFM member noted that the word “trigger” is commonly associated with mental health conditions. Because of personal experiences within her family, she felt it would be better to change this word to “possible causes”. Guidelines for language use and terms associated with dementia largely focus on using person-centered language. For example, in the presentation I used the term “person with dementia” rather than “demented person”. Other terms substituted during the revision of the presentation include “reactions”, “responses”, and “indicators”. These terms are acceptable for use because they do not imply that there is something wrong with the PLWD. Because part of the presentation is about educating the audience on dementia, we cover the fact that dementia is an umbrella term, and there are many different diseases that cause dementia. One DFM member suggested that this could be made easier to understand with the use of a sports analogy. For example, baseball is one type of sport just as Alzheimer’s is one type of dementia. I made the appropriate changes to the presentation and sent it to DFM members for final approval.

Pre- and Post-training Survey

I developed a survey that would be administered both prior to and after the DFM training presentation to evaluate the effectiveness of the presentation. The pre- and post-training survey utilized a five-point Likert scale in order to gauge the audience’s knowledge and attitude towards the presentation topics. In order to prevent survey fatigue, the survey was kept short and consisted of five statements. The participant was prompted to respond to each statement with their level of agreement. I used the presentation learning objectives to guide the writing of the five statements. Each statement encompassed one or more learning objectives. The five-point Likert scale would be displayed as a stacked bar chart for analysis. At the end of the survey, there was a space for comments in order to collect qualitative feedback. The survey would be printed onto a sheet of paper and given to participants to be filled out with pencils or pens. The pre- and post-training surveys were identical to measure change in the audience’s knowledge.

Training handout

I used Canva to create a tri-fold brochure to hand out to audience members. The brochure contained information about Dementia Friendly Manhattan, a brief outline and explanation of the presentation topics, and contact information for DFM. This would allow audience members to take information from the presentation home with them. They could also give the information to family members. Having a physical paper copy of the information would help the audience members absorb information and follow along with the presentation.

Certificate of completion

I used Canva to create the certificate of completion. The certificate contained a line on which the participating business's name could be written. Another line was created to be signed by Debbie Nuss, who is the FHWC chair. Businesses would be able to display the certificate in their establishment to show they had completed the dementia-friendly training.

Window cling

The window cling was also created with Canva. The window cling was made to be hung in the door or window of an establishment, so customers could see it before they enter. The purpose of the window cling was to make PLWD feel welcome and safe in the establishment. Additionally, the recognizability of the window cling would help bring awareness to the program and encourage other establishments to pursue the dementia-friendly training.

Fall Kick-off event

Dementia Friendly Manhattan has planned to host a fall kick-off event at Rockin K's, a locally owned restaurant in Manhattan, KS. I created a flyer and Facebook event cover photo to publicize the event and encourage attendance. We also encouraged attending by offering refreshments provided by Rockin K's. We invited Dr. Susan McFadden to speak at our event. She is a psychologist who specializes in dementia-friendly communities, aging, and how community and friendship impacts aging.

Table 3.1

Dementia by the Numbers

Percent of people aged 65 and older who have Alzheimer's disease in the United States	10.8%
Number of people with Alzheimer's disease in the United States	6.7 million
Number of people with early-onset dementia in the United States	200,000
Number of people with dementia in Kansas	55,000
Total number of residents in Riley County	71,000
Percent of population in Riley County aged 65 and older	10.7%
Estimated number of people aged 65 and older who have Alzheimer's disease in Riley County	820 (71,000 x .108 x .107)

Chapter 4 - Discussion and Next Steps

The main component of this project was the training presentation. As I collected resources for developing this presentation, I noticed there was a lack of resources for helping the employees of various industries interact with PLWD. Dementia Friendly America was the most useful resource for this. Other platforms such as Alzheimer's Association had resources that focused on the caregivers of PLWD. For this presentation, it was assumed that the trainees would have limited familiarity with the customer and would not know definitively whether or not that customer had dementia. Therefore, communication strategies were less personalized and less assumptious than they would be for a caregiver communicating with a loved one.

As I reviewed the literature on dementia-friendly communities, I observed a trend in which focus was placed on the built environment rather than the psychosocial environment. Both are essential components to a dementia-friendly community. However, it is more straightforward to alter the built environment than the psychosocial environment. For example, placing dementia-friendly signage for navigation of a business district is easier than training the employees of each business on how to communicate with PLWD.

One positive observation I made was the enthusiasm that community members had for dementia-friendliness. When I tabled at Everybody Counts, almost everyone I spoke to told me about a loved one they had who was struggling with dementia. This personal connection to the issue motivates community members to support the dementia-friendly initiative and get involved. A major component of a successful public health program is sustained initiative and public support. Dementia-friendliness is a bipartisan issue that is widely supported. For these reasons, I believe dementia-friendly communities will become increasingly common across the United States.

One thing that I found Dementia Friendly Manhattan lacks is the involvement of PLWD and their caregivers. Despite the fact that meetings are held in Meadowlark Hills (a retirement community), there is only one older adult who regularly attends DFM meetings. Public health programs are most successful when they involve the groups they are trying to help in the decision-making. For example, DFM could survey PLWD to understand the challenges they face in the Manhattan, Kansas community. This would allow future DFM initiatives to be tailored to the needs of PLWD in Manhattan, thus maximizing effectiveness.

The turnover rate of employees in some industries is high. Therefore, future consideration must be taken for how frequently businesses should receive DFM training in order to keep their “dementia-friendly” status. One possible solution is the creation of a training video which could be administered by the businesses to their newly hired employees. Dementia Friendly Manhattan could encourage businesses to stay up-to-date on dementia-friendly training by creating a list of businesses that have received the training within a specified period of time, such as a year, on the Dementia Friendly Manhattan website. DFM could also update the window cling and certificate designs with the current year to encourage businesses to continue with DFM training.

As we are asking businesses to participate in this initiative, it would be beneficial to reach out to the businesses to receive their feedback on the program. For example, was the presentation too long or too short? Was there anything they would like included according to their company policies? Would they prefer a Zoom session rather than an in-person training? Would they prefer a pre-recorded session that employees could watch any time? Just as it is important to include PLWD and their caregivers, it is also important to include the businesses in the planning and implementation of this training program.

In the early phases of implementing this project, we will first be reaching out to local businesses. Local business owners may have an increased sense of connection to the community, and thus may be more enthusiastic and willing to participate in an initiative for the betterment of the community. However, many essential businesses in the Manhattan community are large chains and corporations. For example, the main grocery stores in town are Walmart, Dillon’s, and Hy-Vee. In the future, Dementia Friendly Manhattan will have to strategize how to approach these larger businesses for training. Is the store manager able to make the decision to participate in the training, or would we need to seek permission from those higher up in the corporation? The participation of large corporations will be essential to the success of this initiative in Manhattan.

Throughout the remainder of the semester, I will assist DFM in the implementation of the training program. We will host the fall kick-off event, where we will introduce DFM to community stakeholders who are unaware of the program. Both community members in general and business owners are invited to attend the event. At this event, we will network with establishments who are interested in receiving the training. A test-run of the training presentation and survey will be given to a select number of FHWC members who register for the event via an email sent by Debbie. Lunch will be provided at this test-run to encourage attendance. This test-run will allow us to make preliminary changes to the presentation based

on the survey responses before we officially launch the training program with the certificate of completion and window cling. As the training is administered to local businesses, we will continue to utilize the survey to fine-tune the presentation and monitor the baseline levels of knowledge of dementia in the community.

This project allowed me to experience the design and implementation of a community public health program. I created a presentation for education and training that would be administered to community members. I developed products for marketing such as window clings and flyers. I spoke face-to-face with community members to raise awareness about the program and encourage participation. I assisted with the coordination of an event that would launch the training program to a successful start. I gained many skills that will applicable to my future career in public health. Most importantly, I am glad I was able to contribute to increasing the quality of life of PLWD in Manhattan, Kansas.

Chapter 5 - Competencies

Student Attainment of MPH Foundational Competencies

Competency #2: Select quantitative and qualitative data collection methods appropriate for a given public health context

In designing the pre- and post-training survey, I selected quantitative and qualitative data collection methods that would be used to evaluate the effectiveness of the training presentation as a public health program. Likert scales are used to measure opinions, attitudes, and behaviors. I utilized the Likert scale in order to examine the trainees' baseline knowledge and attitude towards their ability to assist someone in the community with dementia, which would then be compared to their knowledge and attitude after receiving the training. Each component of the survey corresponded to a core learning objective of the program. This would allow me to revise the presentation according to which learning objectives were not achieved. The survey included a qualitative component in which respondents could include any comments they had about the training, such as suggestions for improvements or training material that was unclear to them. Designing this survey gave me valuable experience choosing a method for analyzing the effectiveness of a public health program and collecting data. In my coursework, biostatistics (MPH 701) and epidemiology (MPH 754) helped me fulfill this competency. These classes demonstrated the importance of both quantitative and qualitative data, as well as the importance of both prospective and retrospective studies.

Competency #4: Interpret results of data analysis for public health research, policy or practice

The results from the Likert scale component of the pre- and post-training survey would be would presented via a stacked bar chart in order to compare the pre- and post- training surveys. Analysis would mainly focus on baseline levels of knowledge and attitude, as well as the amount of improvement associated with completing the training. Taking the biostatistics class (MPH 701) guided me in the analysis of the survey. I would be able to put the results of the survey into practice by adjusting my presentation based on which learning objectives were not met. Another valuable aspect of the survey would be having the baseline knowledge levels of the audience. This would reaffirm that there is a community need for education, and would allow us to focus more on the topics with which the audience had less knowledge.

Competency #9: Design a population-based policy, program, project or intervention

The training presentation targeted the Manhattan, Kansas and Riley County population. The goal of the presentation was to educate the audience about dementia, raise awareness and reduce the stigmatization surrounding dementia, and equip the audience with the tools needed to assist someone with dementia in their community. I gained experience preparing a

presentation that targets the general public rather than academic peers. I was mindful about the language, the length of the presentation, and the use of interactive components to keep the audience engaged. As a public health official, it will be important to know how to adjust my presentation style according to the target audience. In my healthcare administration class (MPH 720), I conducted a community needs assessment for Santa Barbara, California with a group of peers. We emphasized the issue of homelessness in this area and developed harm reduction strategies to alleviate some of the issues associated with homelessness. This experience was also very valuable for learning how to design a population-based intervention.

Competency #11: Select methods to evaluate public health programs

I selected a survey as the primary method of evaluating the effectiveness and audience response to the training presentation. The survey would allow me to examine which learning objectives were met, and which needed to be adjusted within the presentation. This experience taught me the importance of evaluating public health programs. Effective programs should be backed by data-driven evidence. By choosing to collect data via the survey and apply it to the revision of the presentation, I fulfilled this competency and would improve my public health program.

Competency #16: Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making

The certificate of training completion and window cling were designed to be a recognizable symbol that a space is dementia-friendly. It would create a vision of a whole community where every space and business is dementia-friendly. Applying the principles of leadership that I learned in social and behavioral sciences (MPH 818), I envisioned that as several businesses become dementia-friendly, as indicated with the window cling, other businesses would be encouraged to participate in the training as well. The window cling would foster a sense of community, as it would show that the businesses support people in the community who are living with dementia.

Competency #19: Communicate audience-appropriate public health content, both in writing and through oral presentation

I fulfilled this competency through the development of the Dementia Friendly Manhattan training presentation. The presentation contained basic information about dementia, as the target audience consisted of the general public rather than academic peers. The presentation included a PowerPoint, which was primarily for visual engagement. Accompanying the PowerPoint was an oral component that contained the bulk of the educational content. Audience members were would be given a handout with a condensed version of the information given in the spoken presentation, allowing the audience to follow along and learn through visual, oral, and written presentation of information. In the course Global Health Issues (DMP 844), I created a Tik Tok as a form of communication to young people living in the Unites States. Using this

unique platform to deliver public health information is an example of the novel approaches essential to reaching younger generations.

Table 5.1 Summary of MPH Foundational Competencies

Number and Competency		Description
2	Select quantitative and qualitative data collection methods appropriate for a given public health context	This competency was fulfilled by the designing of a pre- and post-training survey, which included both qualitative and quantitative components. The survey would be provided on paper to audience members before and after the presentation. I selected this data collection method to ensure the target audience were the respondents and to receive better response rates rather than sending an electronic survey that would be completed at a later time.
4	Interpret results of data analysis for public health research, policy or practice	The data collected via the pre- and post-training survey would be analyzed and used to evaluate the effectiveness of the training presentation. By investigating the data collected from this survey, I would be able to put it into practice by using it to improve my presentation.
9	Design a population-based policy, program, project or intervention	The Dementia Friendly Manhattan training presentation was a public health intervention that targeted Manhattan, KS and Riley County business employees. I designed this population-based program to educate business employees on dementia and to teach them the skills they need to effectively assist people living with dementia.
11	Select methods to evaluate public health programs	I selected a survey as the means to collect data which would be used to evaluate the effectiveness of the Dementia Friendly

		Manhattan training presentation. The survey would allow me to examine which learning objectives were met and which were not. Evaluating public health programs is crucial to create a program that is cost-effective, efficient, and beneficial.
16	Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making	The certificate of completion and window cling associated with completing the training was a strategy used to energize the community to encourage more business or other establishments to take part in receiving the training. The visual indication of dementia-friendly spaces would guide others to make their own spaces dementia-friendly. In this way, Dementia Friendly Manhattan would create a vision of all public spaces being dementia-friendly. The use of window clings would empower business employees and allow them to feel confident when helping customers who may have dementia, and empowers PLWD to navigate in their community and visit stores.
19	Communicate audience-appropriate public health content, both in writing and through oral presentation	I would deliver the training presentation as a PowerPoint accompanied by an oral component. The information regarding educating the audience on dementia was kept at a basic level for the general public. The PowerPoint contained minimal text and was designed to keep the audience engaged. Additionally, audience members would receive a handout that roughly followed along with the content of the presentation. This way, audience members

		had three ways in which to absorb information: oral, visual, and written.

Table 5.2 MPH Foundational Competencies and Course Taught In

22 Public Health Foundational Competencies Course Mapping	MPH 701	MPH 720	MPH 754	MPH 802	MPH 818
Evidence-based Approaches to Public Health					
1. Apply epidemiological methods to the breadth of settings and situations in public health practice	x		x		
2. Select quantitative and qualitative data collection methods appropriate for a given public health context	x	x	x		
3. Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software, as appropriate	x	x	x		
4. Interpret results of data analysis for public health research, policy or practice	x		x		
Public Health and Health Care Systems					
5. Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings		x			
6. Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels					x
Planning and Management to Promote Health					
7. Assess population needs, assets and capacities that affect communities' health		x		x	
8. Apply awareness of cultural values and practices to the design or implementation of public health policies or programs					x
9. Design a population-based policy, program, project or intervention			x		
10. Explain basic principles and tools of budget and resource management		x	x		
11. Select methods to evaluate public health programs	x	x	x		
Policy in Public Health					
12. Discuss multiple dimensions of the policy-making process, including the roles of ethics and evidence		x	x	x	
13. Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes		x		x	
14. Advocate for political, social or economic policies and programs that will improve health in diverse populations		x			x
15. Evaluate policies for their impact on public health and health equity		x		x	
Leadership					
16. Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making		x			x
17. Apply negotiation and mediation skills to address organizational or community challenges		x			
Communication					

22 Public Health Foundational Competencies Course Mapping	MPH 701	MPH 720	MPH 754	MPH 802	MPH 818
18. Select communication strategies for different audiences and sectors	DMP 815, FNDH 880 or KIN 796				
19. Communicate audience-appropriate public health content, both in writing and through oral presentation	DMP 815, FNDH 880 or KIN 796				
20. Describe the importance of cultural competence in communicating public health content		x			x
Interprofessional Practice					
21. Perform effectively on interprofessional teams		x			x
Systems Thinking					
22. Apply systems thinking tools to a public health issue			x	x	

Student Attainment of MPH Emphasis Area Competencies

The MPH competencies for the Infectious Diseases and Zoonoses (IDZ) emphasis are listed in table 5.3. I achieved the competencies through my coursework, including core courses, IDZ emphasis required courses, and electives.

Table 5.3 Summary of MPH Emphasis Area Competencies

MPH Emphasis Area:		
Number and Competency		**Description**
1	Pathogen/pathogenic mechanisms	Evaluate modes of disease causation of infectious agents.
2	Host response to pathogens/immunology	Investigate the host immune response to infection.
3	Environmental/ecological influences	Examine the influence of environmental and ecological forces on infectious disease.
4	Disease surveillance	Analyze disease risk factors and select appropriate surveillance.
5	Disease vectors	Investigate the role of vectors, toxic plants, and other toxins in infectious disease.

Competency #1: Pathogen/pathogenic mechanisms

In pathogenic microbiology (BIOL 530), I learned about the mechanisms of pathogenicity of many species of bacteria. Some mechanisms covered include having an outer capsule, flagella, the release of enzymes such as hyaluronidase, or the ability to undergo antigenic shift. In Human Parasitology (BIOL 545) I learned about the complex lifecycles of many parasites. Different parasites may enter the body in different ways or may require specific conditions to

infect humans, such as the host and pathogen being submerged in water. The evaluation of modes of disease causation is crucial to the control of infectious disease. For example, some human diseases have animal reservoirs. In these cases, controlling the disease in animals is often the first step to preventing the disease in humans.

Competency #2: Host response to pathogens/immunology

In Immunology (BIOL 670), I learned about the coevolution of humans alongside pathogens as humans developed new mechanisms of defense and pathogens developed new mechanisms of evasion. For example, our immune systems are able to create vast numbers of antigen-specific B and T cells to counter the antigenic shift of bacteria. I also learned how vaccination can aid host response to pathogens in Vaccinology (AAI 852). Investigating the host immune response to infection is crucial to the development of vaccines. Additionally, researchers must examine the excessive host responses that can damage the host, such as with severe COVID-19 infections exacerbated by inflammation of the lungs.

Competency #3: Environmental/ecological influences

I learned about the relationship between host, agent, and environment in One Health (DMP 710) and Environmental Health (MPH 802). As humans continue the processes of globalization, deforestation, and urbanization, the landscape of infectious disease will change. For example, the areas affected by tickborne diseases will grow as the climate becomes warmer and more hospitable for ticks. The warming of the ocean has already resulted in increased Vibrio infections. Examining the environmental and ecological forces of disease will become increasingly important with climate change.

Competency #4: Disease surveillance

In Introduction to Epidemiology (MPH 754) I learned how to analyze risk to identify risk factors using calculations such as relative risk or odds ratio. I learned how to select the best study design for gathering data on risk. For example, selecting a case vs. cohort study or whether a cohort study should be prospective or retrospective. I also learned about different methods of disease surveillance, such as a yearly measure of prevalence or incidence. Analyzing disease risk factors and selecting appropriate surveillance measures is a crucial part of being an epidemiologist at the Kansas Department of Health and Environment. With my job as a public health consultant, I was able to assist with the surveillance of Salmonella and Shiga toxin-producing E. coli.

Competency #5: Disease vectors

I learned about a vast array of disease vectors in Human Parasitology (BIOL 545). For example, some species of mosquitos can transmit the pathogen that causes malaria, and certain species of ticks carry pathogens specific to that species. In Vaccinology (AAI 852) I learned how pathogens that are spread by a vector are harder to control than pathogens only found in humans. Any pathogen with a nonhuman reservoir is harder to control or eliminate. One of the most interesting things I learned in pathogenic microbiology (BIOL 530) was how sometimes a disease is caused by toxins that a microbe produces rather than the microbe itself. This is how diphtheria was able to be effectively treated, even before the creation of antibiotics.

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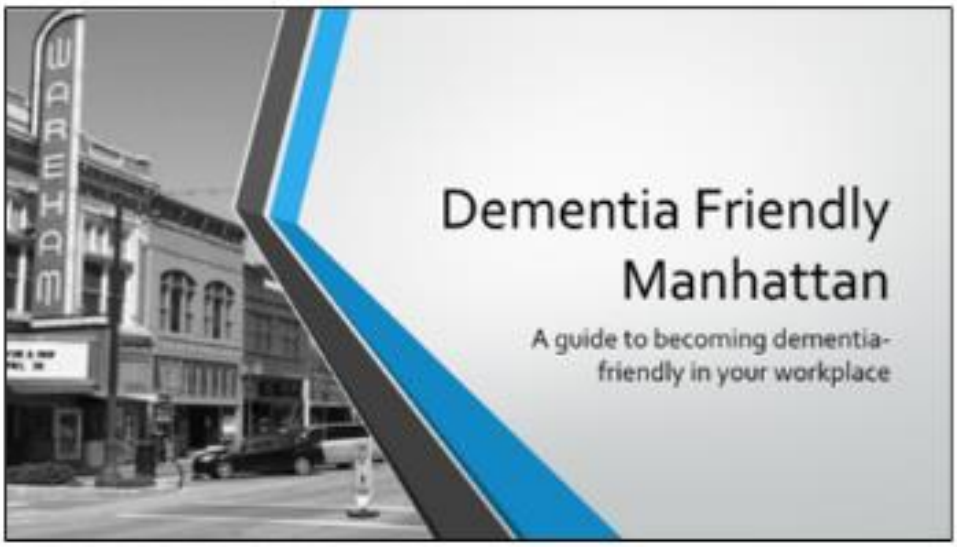
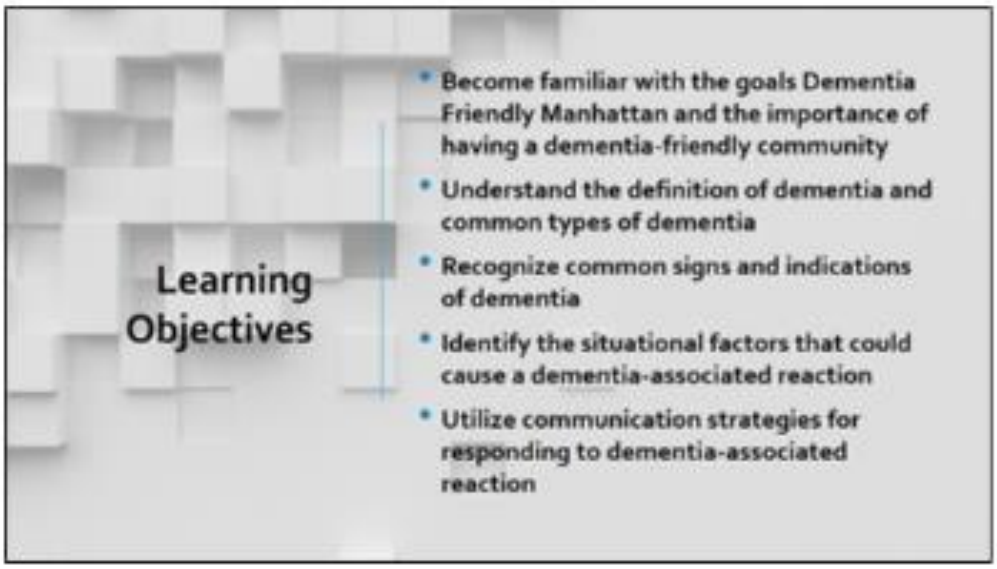
Appendix

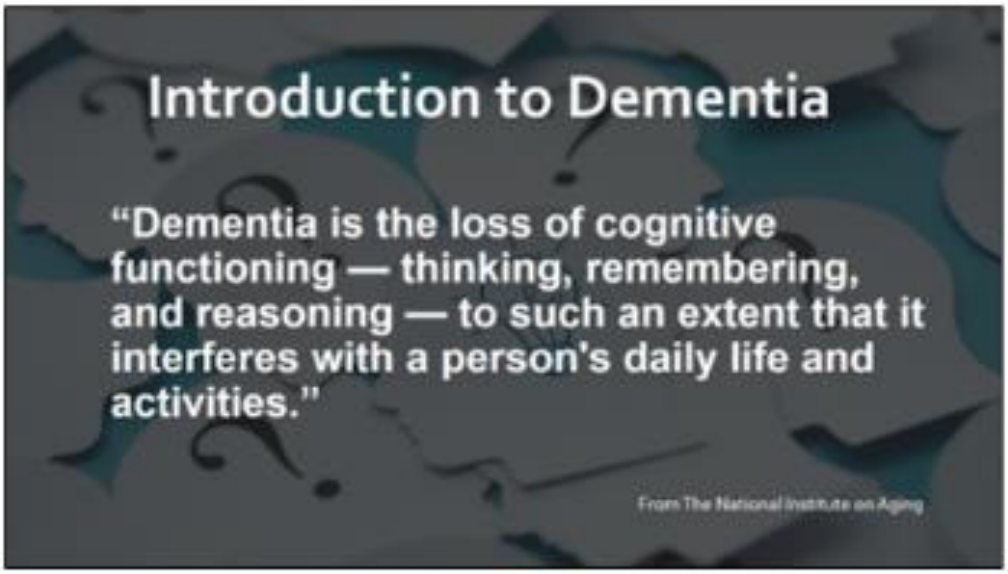
Training presentation



Hello, everyone. Thank you for being here today. I am _____ and I am here to represent Dementia Friendly Manhattan. We are going to talk about dementia and what it means to create a dementia-friendly community.



Let's go over our learning objectives for today. We will start by introducing you to Dementia Friendly Manhattan and our goals. We will learn more about what dementia is and how it affects people. Then, we will go over 10 potential signs of dementia. These signs will help us recognize when someone might dementia and need help. We will also talk about how dementia can affect the way people react to situations and communicate. People with dementia may use behavior to communicate instead of words. We have some tools we can use to assess the situation to see what is causing their reaction to a situation. There are also tools we can use when communicating with someone who has dementia or responding to a dementia-associated reaction. We will go over some communication strategies. Finally, we will put what we learned to the test by going over some real-world scenarios.

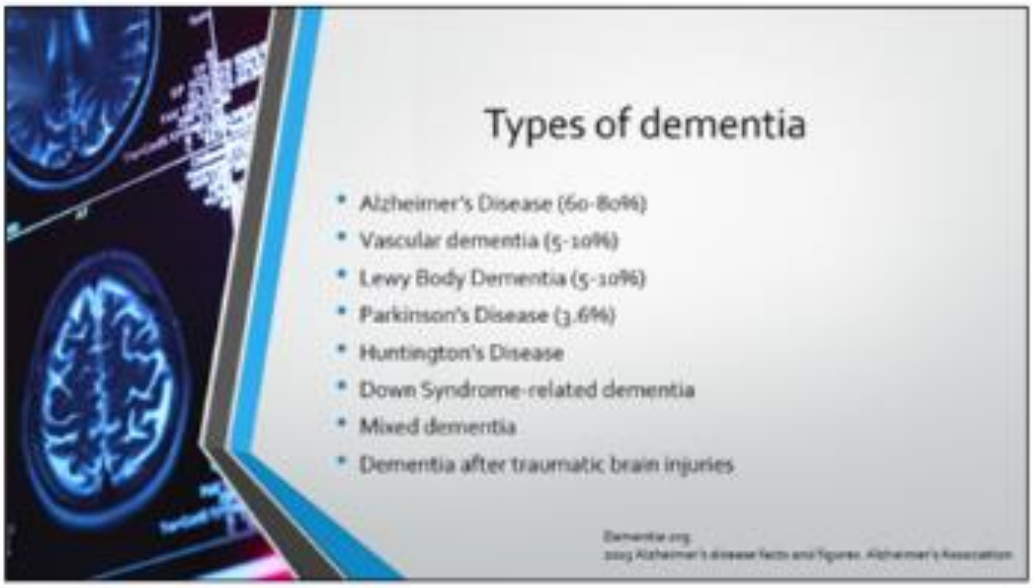


According to the National Institute on Aging, dementia is the loss of cognitive functioning – thinking, remembering, and reasoning – to such an extent that it interferes with a person's daily life and activities. Let's do some true and false questions to learn some facts about dementia and debunk misconceptions about dementia.

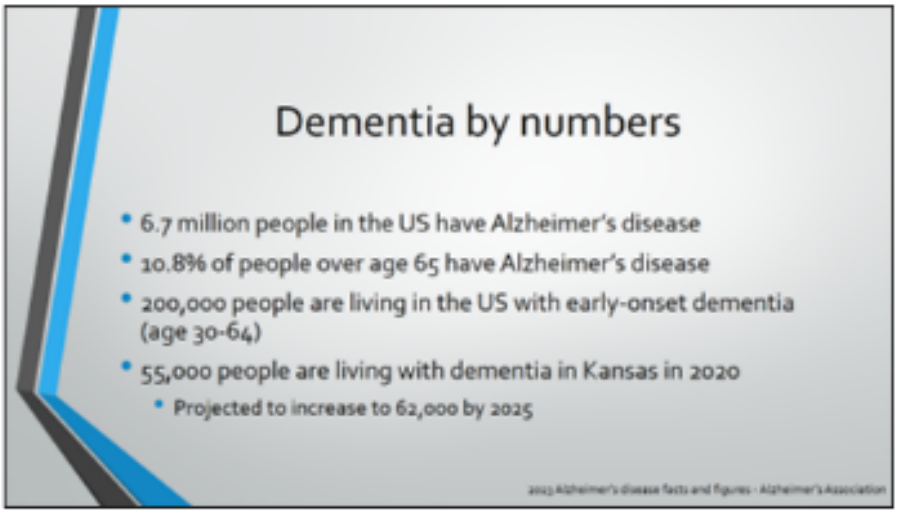
True or false: dementia is a normal part of aging. This is false. Older age is the biggest risk factor for having dementia, but it is not a normal part of aging. While it is normal to have a decline in memory or attention as you age, it is gradual and does not affect your ability to function in everyday life. With dementia, the decline in cognition is more rapid and severe, and interferes with daily life.

True or false: People under 65 can have dementia. This is true. When someone under 65 develops dementia, it is called “early onset dementia”. Each year, an increasing number of people are diagnosed with early onset dementia.

True or false: Alzheimer's Disease and dementia are the same thing. This is false. Dementia is an umbrella term for the decline in cognition, which can be caused by many different health conditions. Alzheimer's Disease is the most common cause of dementia. Think of it this way: just like baseball is a category of sport, Alzheimer's Disease is a category of dementia. Let's talk a little bit more about the different types of dementia.

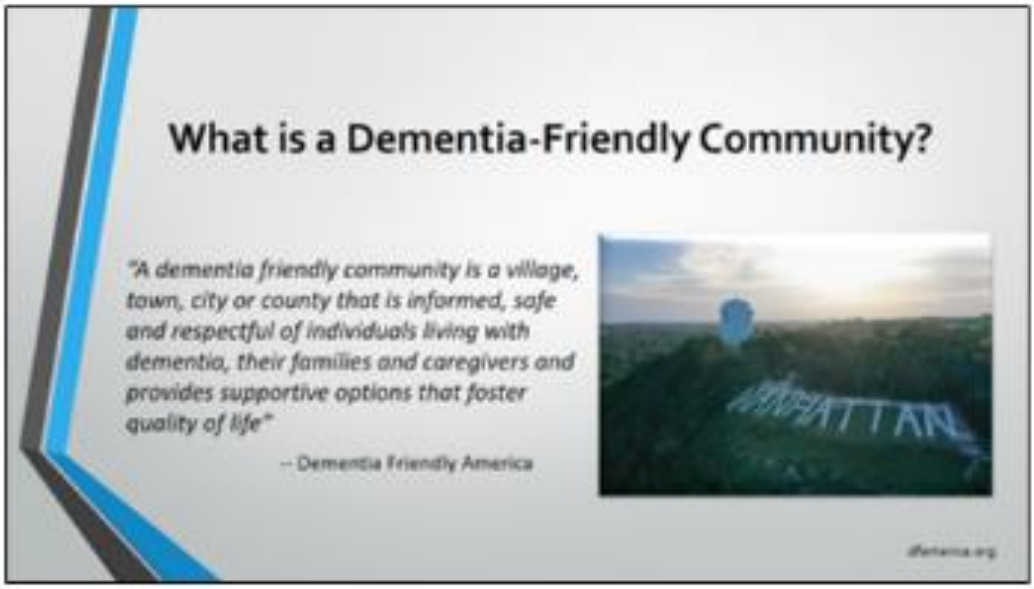


As we just learned, Alzheimer's disease is the most common cause of dementia, causing 60-80% of dementia cases. This disease is progressive, and there is no cure. This means that the severity of the symptoms will increase over time. Vascular dementia is the next most common type of dementia. It occurs when oxygen is unable to reach the brain, such as during a stroke. Lewy Body dementia, Parkinson's disease, and Huntington's disease are some less common progressive neurological diseases that cause dementia. People with Down Syndrome are at a high risk of developing dementia, especially early onset dementia. 30% of people in their 50's with Down Syndrome have Alzheimer's disease. Mixed dementia refers to cases in which the individual has multiple diseases contributing to their dementia. Lastly, we want to include people who have dementia following a traumatic brain injury. This drives home the fact that people of any age can have dementia, and Dementia Friendly Manhattan wants to make sure all types of dementia are included when we talk about making our community dementia-friendly.



The United States Census Bureau and the Chicago Health and Aging Project has estimated there to be 6.7 million people living with Alzheimer's in the US. This number does not include people who are living with other types of dementia. About 10.8% of people over the age of 65 have Alzheimer's. An estimated 200,000 people aged 30-64 in the US have early-onset dementia. In 2020, there were 55,000 people in Kansas living with dementia. This number is projected to increase to 62,000 by 2025. The United States' Census Bureau's most recent estimate of the population of Riley County was 71,000. 10.7% of the population consists of people aged 65 and over. If 10.8% of people aged 65 and over have Alzheimer's, then there is approximately 820 people in Riley County living with Alzheimer's disease.

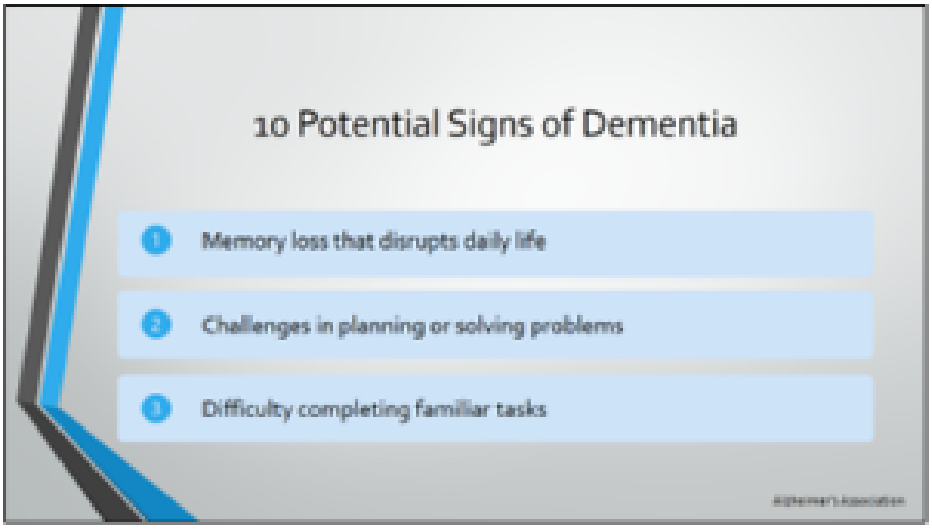
Dementia Friendly America is a nation-wide network of communities that have come together with the goal of making their communities "dementia-friendly". In 2021, the Flint Hills Wellness Coalition here in Manhattan worked with Dementia Friendly America to launch Dementia Friendly Manhattan. Manhattan is the first community in Kansas to become part of the Dementia Friendly America network. The mission of Dementia Friendly Manhattan is to make Manhattan, KS a more inclusive, supportive, and engaging community for people with dementia and their care partners.



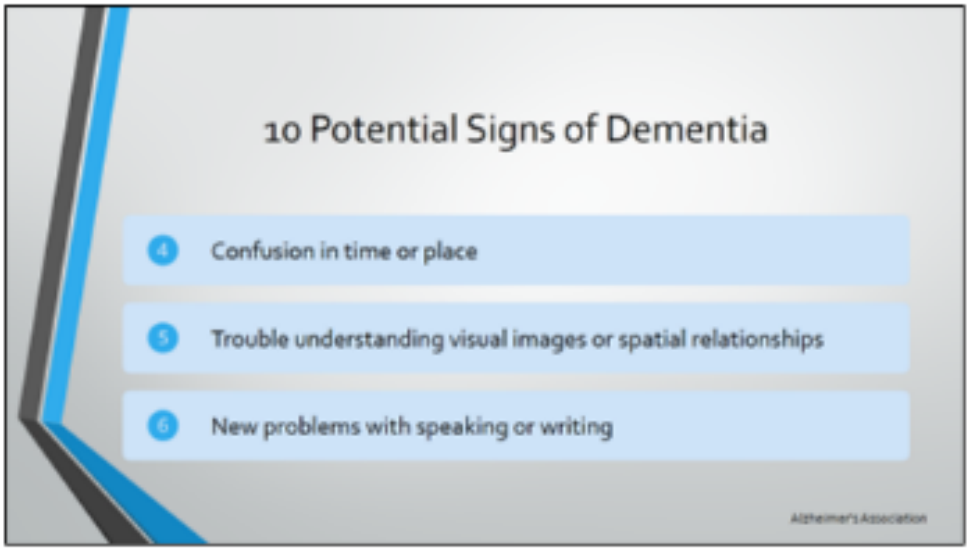
Let's talk a little more about what exactly a dementia friendly community is. Dementia Friendly America defines a dementia friendly community as "a village, town, city or county that is informed, safe and respectful of individuals living with dementia, their families and caregivers and provides supportive options that foster quality of life."

Part of being a dementia-friendly community includes educating the people in the community on how they can best support and communicate with people who have dementia. This information can be useful in a personal setting, such as helping out a neighbor in need, or a commercial setting, such as assisting a customer in your place of work. That is just one example of many aspects that go into creating a dementia-friendly community. There are many other factors such as transportation, housing, memory services and other healthcare, or other public services. Today we will be focusing on the social aspects of being a dementia-friendly community. By this, I mean we will be talking about how we can be dementia-friendly through our interactions with people in the community who have dementia. Before we get into that, let's discuss why it is important to have a dementia-friendly community in the first place.

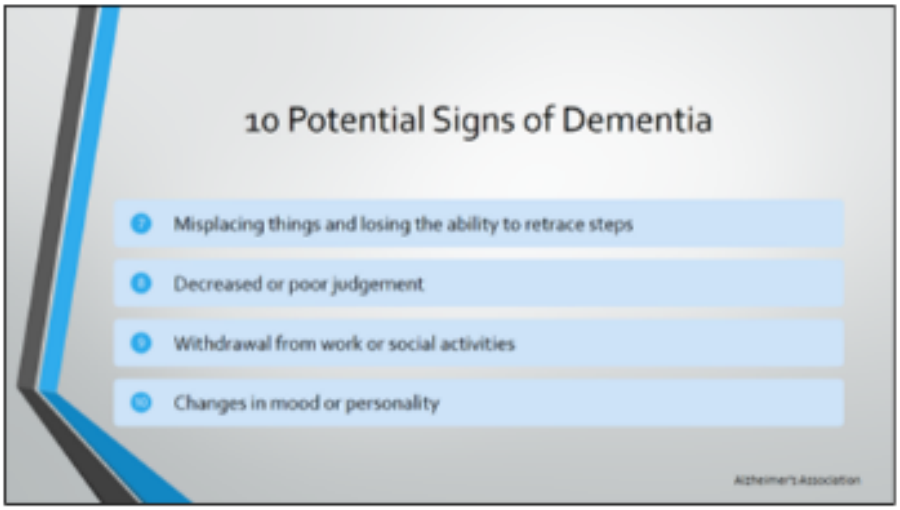
According to Dementia Friendly America, a dementia-friendly community can allow people with dementia to remain in their homes and communities as they age, allowing for increased independence and quality of life. Many seniors wish to age in place. This is when a senior stays in their own home for as long as possible, surrounded by friends, family, and neighbors rather than moving into an assisted living facility. Developing a dementia-friendly community increases the likelihood of seniors in the area being able to age in place.



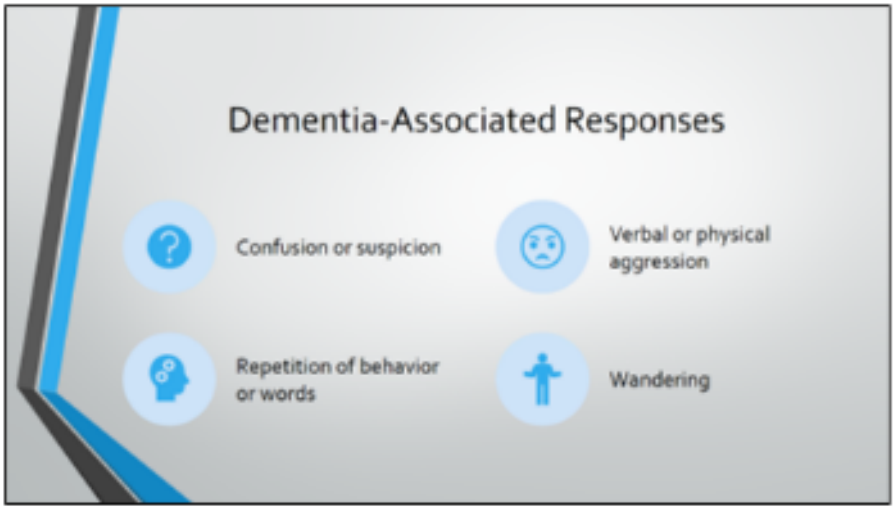
Now that we have learned about what dementia is and what it takes to be a dementia-friendly community, let's learn more about how we can foster a dementia-friendly community through our social interactions with people who have dementia. There are 10 general signs of dementia. These signs can help us identify if someone may be struggling with dementia in case they need help. The first sign is memory loss that disrupts daily life. We need to remember that some slight cognitive decline occurs in normal aging. Let's compare an example of memory loss that could indicate dementia and an example of memory loss that is "normal" when aging. If someone forgot the name of an acquaintance they ran into at the store and couldn't remember it until later that day, that would be pretty normal. If someone ran into a friend at the store and did not recognize who they were, that could be in indication of dementia. The second sign is challenges in planning or solving problems. For example, a regular grocery store patron tries to pay for their groceries, but becomes confused when trying to pay with exact change like they normally do. Number three: difficulty completing familiar tasks. For example, a woman in your church has always brought her signature dish to church dinners, but she mentions the recipe "doesn't turn out right" anymore.



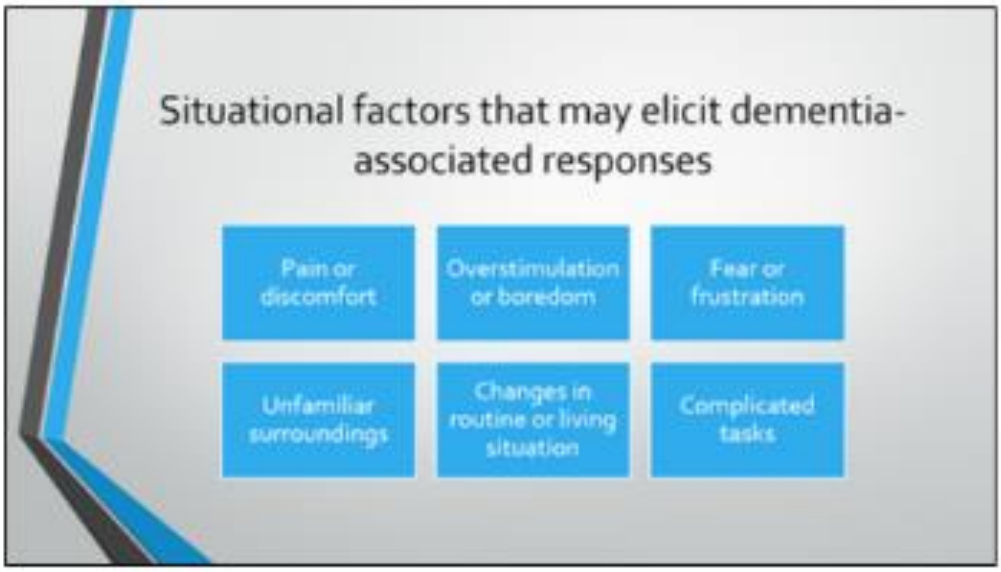
Number four: confusion in time or place. For example, you see that your neighbor has been circling the block in his car. You ask him if he needs help, and he says he is coming home from the post office and is having trouble finding his house. Number five: trouble understanding visual images or spatial relationships. Dementia can affect your depth perception, making you prone to falling on the stairs or getting into a car accident. It can also alter your ability to recognize objects or people, so it can be common to lose objects even when they are in plain sight. Number six: new problems with speaking or writing. For example, you work at the bank and have a customer who comes in every week to make a deposit. You notice that their handwriting on the deposit slip has been getting harder to read. Some of the numbers may even just look like scribbles.



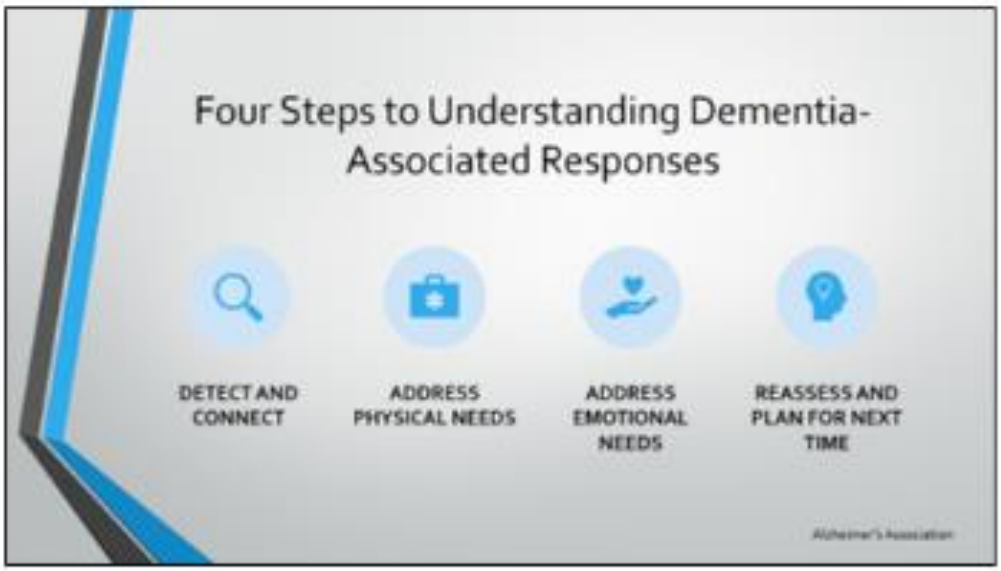
Number seven: misplacing things and losing the ability to retrace steps. Everybody misplaces things like their keys sometimes, but if you notice that someone is losing things more often and is unable to find them, it could be a warning sign of dementia. Number eight: decreased or poor judgement. People with dementia might spend or give away their money irresponsibly. They might wear shorts in the middle of winter. Maybe they have gotten in a few too many fender benders but are refusing to give up driving. Number nine: withdrawal from work or social activities. Many people with dementia become withdrawn or isolated. This often stems from difficulty with communication as the disease progresses. Lastly, the tenth potenital sign of dementia is changes in mood or personality. The most common changes include irritability, anger, frustration. and depression.



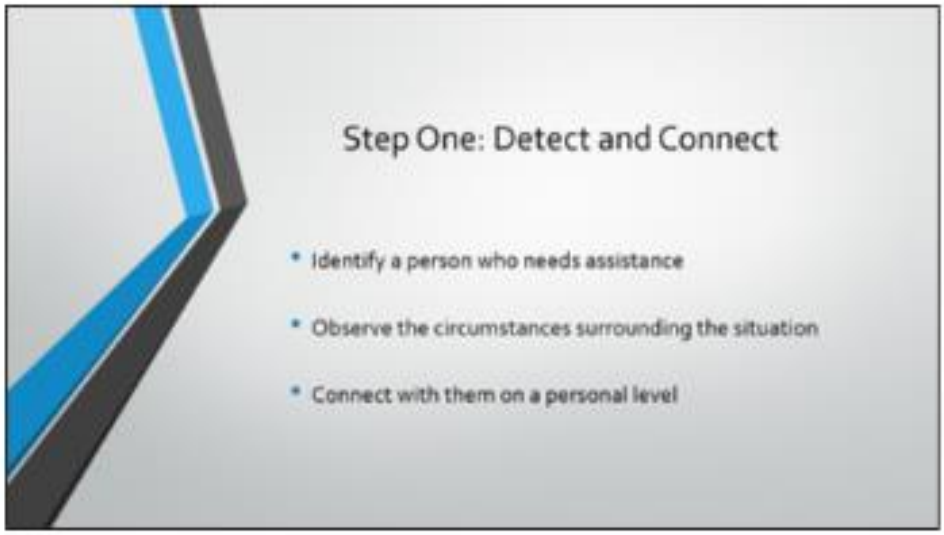
It can become difficult for a person with dementia to express their feelings verbally. As a result, they may use behavior as a way of communicating. These behaviors include confusion or suspicion, verbal or physical aggression, repetition of behavior or words, and wandering. While the person's reaction to a situation may seem irrational, we can oftentimes begin to understand their reaction by remembering that behavior is a response to an unmet need. They are using behavior instead of words to communicate.



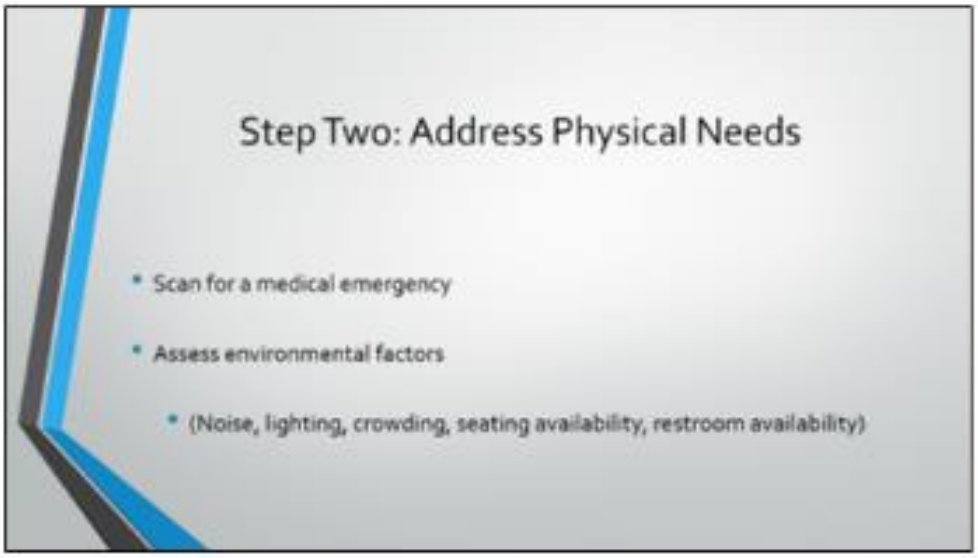
Let's go over some situational factors that can cause dementia-associated responses. These factors can be anything from an emotion such as boredom or a physical aspect of the environment such as sound or lighting. When we discover what is causing the response, it can help us to identify their unmet need that they are trying to communicate to us.



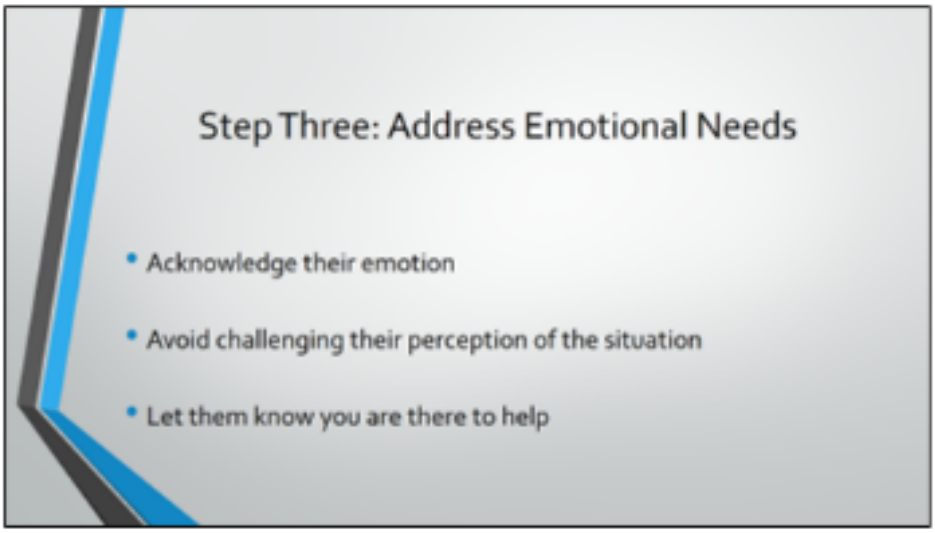
The Alzheimer's Association has developed four steps for understanding and addressing responses associated with dementia. The steps are "detect and connect", "address physical needs", "address emotional needs", and "reassess and plan for next time". Let's go over what exactly these steps mean.



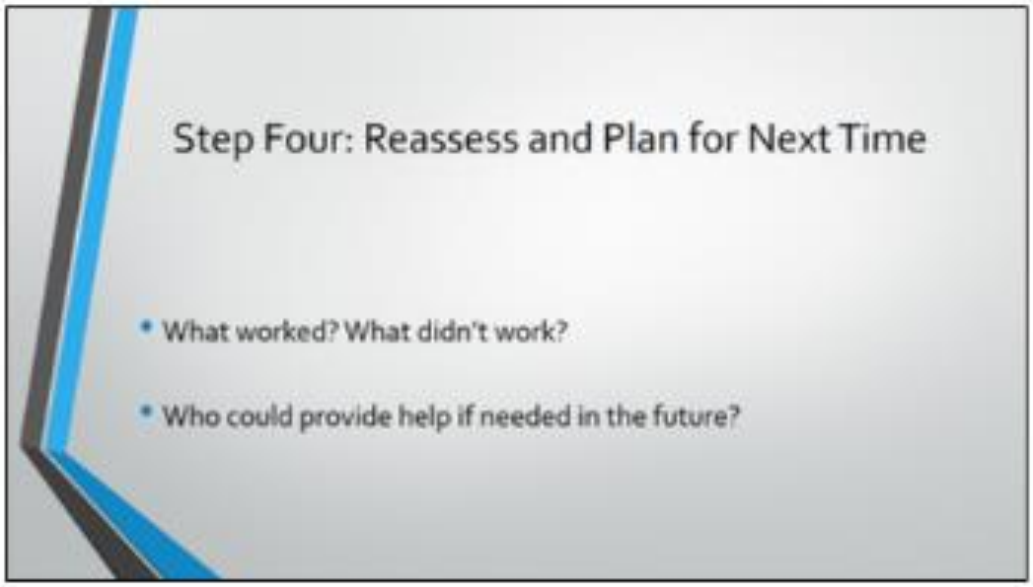
Step one: detect and connect. First, we need to detect that a person may be in need of assistance by noticing what could be a dementia-associated response. As we previously talked about, this could manifest as confusion, suspicion, agitation, or wandering. Remember: behavior is used as a way to communicate an unmet need. Observe the circumstances before, during, and after the response took place. This is all about the who, what, when, and why of the situation. Try to see through their eyes. What is their reality? Next, it's time to connect with the person. Approach the person calmly and respectfully from the front. Start by identifying yourself while maintaining friendly body language and tone of voice. Your body language is easier to interpret than words.



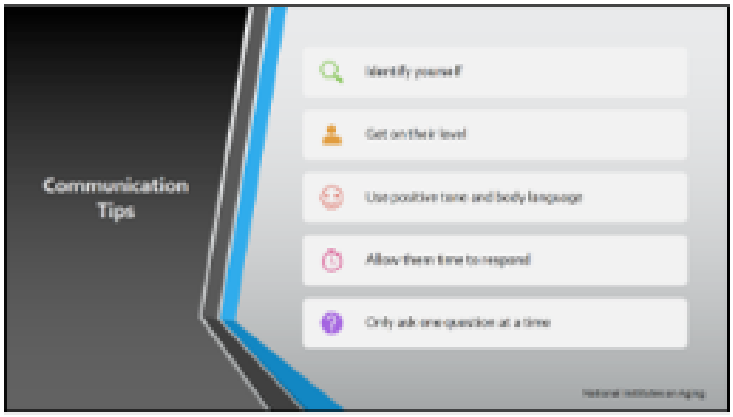
Now that we have connected with the person, it's time for step two: address physical needs. First, we want to make sure the person is not having a medical emergency. Scan for obvious signs of injury, such as bruises that could be from falling. Any sudden or drastic change in the person's condition could indicate a medical crisis. If they seem to be in a stable condition, look around at the environment. Does the person need a place to sit down? Is there excessive noise or crowds? Is the person too hot or cold? Do they need to use the restroom? All of these things could be the unmet need that the person is trying to express.



The next step is to address emotional needs. This is based on how the individual is feeling rather than facts. Try to avoid "reality checks" or correcting the person's perception of the situation. It's not always possible to determine the root cause of the person's response. However, you can usually identify the emotion that is driving the response, such as fear, anger, agitation, boredom, or frustration. You can ask the individual if they are feeling that specific emotion, which can help them feel understood and less alone. Let the person know that they are safe and you will try to make them more comfortable. Then, try to redirect their energy into a soothing or enjoyable activity.



Finally, it's time to reassess and plan for next time. Did your strategy help? Are there other possible causes of their response or other solutions to explore? There is no "one-size-fits-all" way to handle the situation. For future reference, think about what you could do if the situation were to escalate, and identify who could help.

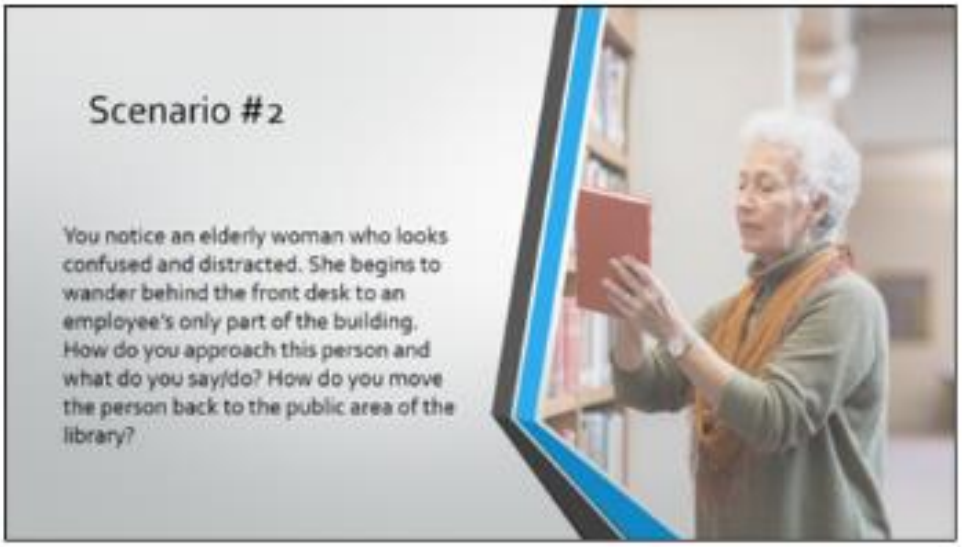


Before we dive into some scenarios, let's go over some general tips for communicating with people who have dementia. First, it's important to identify yourself, even if the person has met you before. Next, get on their level by bending down if they are sitting down or in a wheelchair. This will help you make eye contact and connect with the person. As we talked about earlier, be mindful that your facial expression, body language, and tone of voice are friendly. As you talk with the person, they might need a little extra time to put their thoughts and feelings into words. Give them this extra time, but don't be afraid to suggest a word if they seem to be searching for the right word to use. Only ask them one question at a time. It's also better to avoid open-ended questions, and instead opt for yes or no questions or provide a choice for them. For example, rather than asking "what payment are you using today, and what type of bag would you like your groceries in?" you could say "are you paying with cash or card?". Allow them to respond, then follow up with "Would you like your groceries in a paper or plastic bag?". Lastly, remember that everyone's dementia manifests in different ways, and people may respond differently to interventions. An individual can even respond differently to the same strategies and interventions from day-to-day. There's no "perfect" way to handle every situation. It's important to be able to adapt your strategy based on the individual's response.

Let's put the skills we learned to the test by going through some real-world scenarios. You are the cashier at a retail store. A customer appears to be having a difficult time selecting an item. When they do select the item, they turn and walk slowly to the exit. You approach this person before they leave the business. What do you say/do? If they argue with you or become agitated, what strategies can you use to calm the situation?

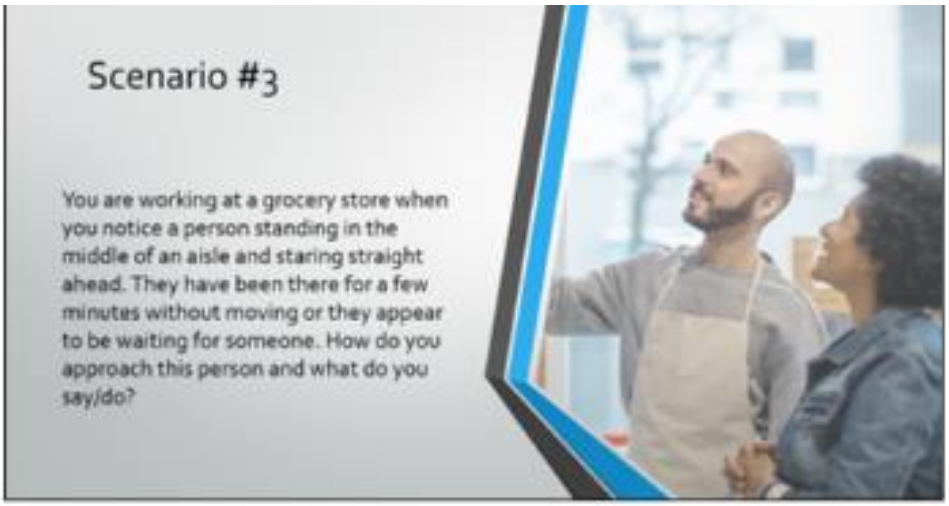
Encourage audience members to voice their ideas to the group.

- Approach the person from the front slowly and calmly with a smile.
- If you know his or her name, use it.
- Introduce yourself and ask if you can help.
- Point to and offer to walk with the person to a cashier.
- If the person argues or becomes upset, just listen. If you remain calm, it will help him or her calm down, too.
- Apologize for your "miscommunication" and offer again to walk to the cashier with the person. You may need to let him or her walk out with the item.



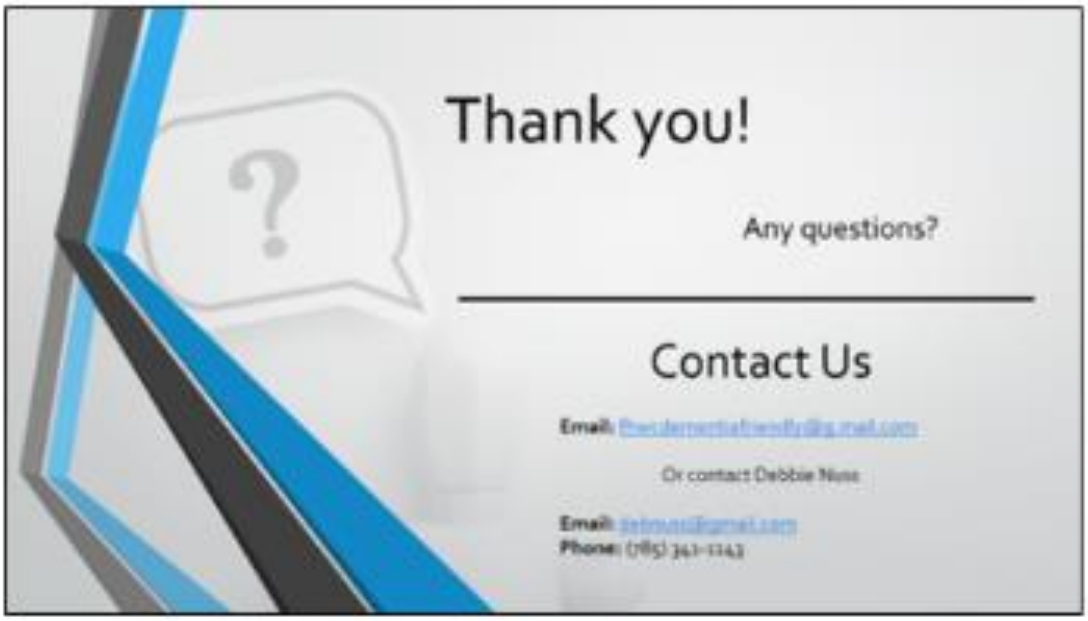
Let's move on to the next scenario. You a librarian at the local community library. You notice an elderly woman who looks confused and distracted. She begins to wander behind the front desk to an employee's only part of the building. How do you approach this person and what do you say/do? How do you move the person back to the public area of the library?

- Approach the person from the front slowly and calmly with a smile.
- If you know her name, use it and tell them your name.
- Ask if you may help them find something such as a restroom or lounge area.
- To help move the person back to the public area, apologize for the confusion and gently turn them back to the public area by moving your body. Move slowly and calmly.
- If possible, stay with the person until they reach their desired area of the library



Let's go over our final scenario. You are working at a grocery store when you notice a person standing in the middle of an aisle and staring straight ahead. They have been there for a few minutes without moving or they appear to be waiting for someone. How do you approach this person and what do you say/do?

- Approach the person from the front, make eye contact and introduce yourself.
- Ask if you may help him or her.
- Take cues from the person. Do not argue. Offer support.
- Move to a quiet area.
- If you do not know this person, ask their name and address or to see their identification card so that you can help.
- Look for a Medic Alert bracelet for identification.
- If possible, contact a family member to come and escort the person home.
- Again, if necessary, contact the police to come and help. The important thing is to make sure the person is safe and has a safe place to go.



That concludes our program for today. Thank you all for your time and attention. We hope that you take what you learned out into the community to help make Manhattan dementia-friendly. If you have any questions or would like to learn more about getting involved with Dementia Friendly Manhattan, please feel free to come talk to us.


Sources
National Institute on Aging (nih.gov)
Dementia: Symptoms, Causes, Types & Treatments - Dementia.org
Alzheimer's & Dementia | Alzheimer's Association
Dementia Friendly America (dfamerica.org)
Home | Dementia Friendly Manhattan (dfmanhattanks.org)

Training pre- and post- survey

Dementia Friendly Manhattan: How to be "dementia-friendly" in your workplace

Please read the following statements and circle the option that most accurately reflects your level of agreement.

1. **I am familiar with the concept of "dementia-friendly communities".**

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

2. **I understand what dementia is and who it affects.**

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

3. **I can identify signs and behaviors that are associated with dementia.**

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

4. **I can list situational factors that may contribute to someone with dementia exhibiting dementia-related behavior.**

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

5. **I would feel confident approaching someone in my workplace or community who was exhibiting signs of dementia and may be in need of assistance.**

Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

Other comments:

_____

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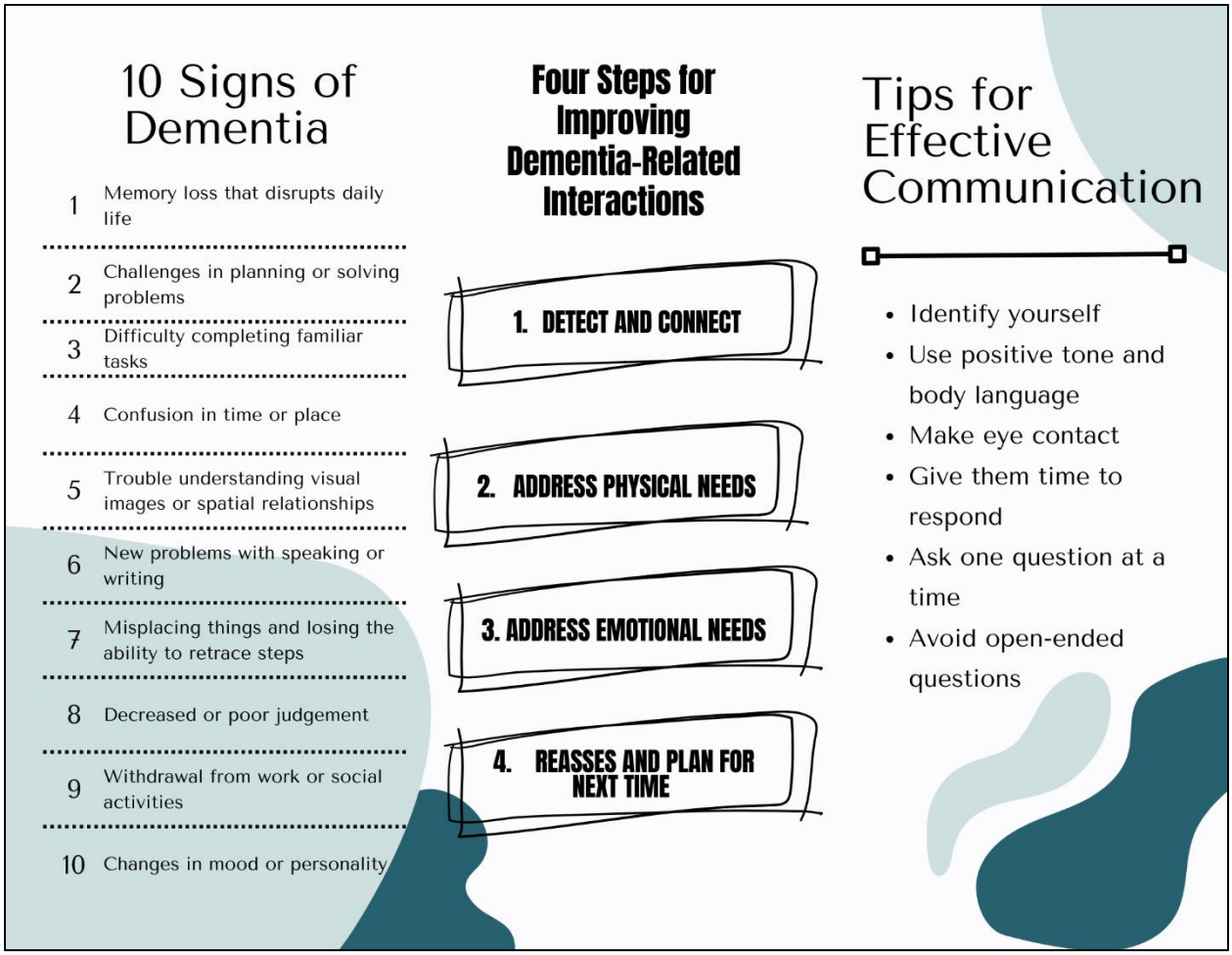
Training supplemental handout


10 Signs of Dementia
1 Memory loss that disrupts daily life
2 Challenges in planning or solving problems
3 Difficulty completing familiar tasks
4 Confusion in time or place
5 Trouble understanding visual images or spatial relationships
6 New problems with speaking or writing
7 Misplacing things and losing the ability to retrace steps
8 Decreased or poor judgement
9 Withdrawal from work or social activities
10 Changes in mood or personality
Four Steps for Improving Dementia-Related Interactions
1. DETECT AND CONNECT
2. ADDRESS PHYSICAL NEEDS
3. ADDRESS EMOTIONAL NEEDS
4. REASSES AND PLAN FOR NEXT TIME
Tips for Effective Communication
• Identify yourself
• Use positive tone and body language
• Make eye contact
• Give them time to respond
• Ask one question at a time
• Avoid open-ended questions

Training certificate of completion

Window cling

Fall kick-off flyer

Scan the code to register by October 23 at 12:00 pm

Kick-off Event

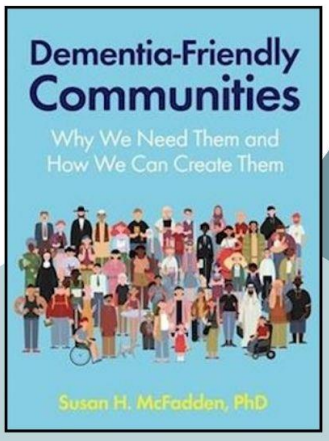
Dementia Friendly Manhattan

Join us to learn why your business should be dementia friendly

Where: Rockin K's Meeting Room
1880 Kimball Ave Ste 100
Manhattan, Kansas 66502

When: Monday, October 30
5:30–6:30pm

Light refreshments will be served



Featuring guest speaker

Susan H. McFadden, PhD

Author of "Dementia-Friendly Communities: Why We Need Them and How We Can Create Them"

Dementia Friendly Manhattan
A Flint Hills Wellness Coalition Project

Fall kick-off Facebook event cover

"Dementia by the Numbers" infographic

TikTok video.mp4

Tik Tok for Global Health Issues (DMP 844)