The Brain Trust Podcast |Episode #8: Early Detection in FQHC's

Transcript

Speaker 1: Kate Rowland, MD

Welcome to the Brain Trust, A Physician's Guide to Diagnosing Alzheimer's Disease and Related Dementias. Brought to you from the Illinois Academy of Family Physicians. I'm Dr. Kate Rowland, family physician, member of the IAFP and faculty at Rush University. Funding for this podcast series was provided by a grant from the Illinois Department of Public Health. The goal of the Brain trust in this podcast series is to educate and empower the primary care clinician in the early detection, diagnosis and management of Alzheimer's disease and related dementias.

Clinical resources, Free CME and other educational materials are available online at theBrainTrustProject.com. CME Credit is available for each podcast. The Illinois Academy of Family Physicians is accredited by the Accreditation Council of Continuing Medical Education to provide continuing medical education for physicians. Information on how to receive credit can be found on the Brain Trust Project website.

Thank you for joining us. As we empower each other and provide training on the early detection of Alzheimer's disease and related dementias. And now today's episode.

00;01;08;02 - 00;01;30;17

Speaker 2: Raj Shah, MD

Today, I think we have a really great episode for the Brain Trust of Physicians Practical Guide to Alzheimer's and Related Dementias. So again, just to remind you, I'm Dr. Rod Schaal. I'm a professor of family of preventive medicine and the Russian Alzheimer's disease at Rush University and a co-host of the Brain Trust as a program put together by the Illinois Academy of Family Physicians.

And today, we're going to have a wonderful opportunity to really learn how things work in federally qualified health centers, especially for primary care and family physicians working in federally qualified health centers, and how they tackle the barriers, the needs for their patients that might be experiencing difficulties with cognition and need help with early diagnosis and detection. So hi, how are you?

Thanks for allowing me to come today and visit with you and to spend some time with our podcast on the Brain Trust. How are you doing today?

00;02;04;11 - 00;02;08;19

Speaker 3: Emma Daisy, MD

I'm great, thanks Raj, and welcome. It's so nice to have you here at Tapestry.

00;02;09;02 - 00;02;36;16

Speaker 2: Raj Shah, MD

Yeah, it's my first time coming down to Tapestry, and I really enjoy the diversity of the neighborhood. I was driving through on my way here as somebody of Indian origin. I mean, I visited closer to Rogers Park because of Devine Avenue and all of the Indian and Southeast Asian cultures and activities and restaurants and shopping places there. But I've never realized that Tapestry 360 Health was also an anchor institution in this neighborhood.

But I was curious as we get started, Emma, if you could tell us a little bit about your journey about becoming a family physician, geriatrician and working in a federally qualified health center?

00;02;47;18 - 00;03;12;07

Speaker 3: Emma Daisy, MD

Yeah. Thanks, Raj. Thanks for the question. You know, all of my post-graduate training pretty much was at in UHC, except for the one year I did my fellowship at the University of Chicago. But I was in the second class of residence at the Erie Erie Family House, Northwestern University partnership of bringing the residency, you know, actually anchoring the residency in the UHC rather than in the hospital.

So that's been my, you know, my intention all along has been to practice community based medicine. And even at the University of Chicago, one of the things I liked about that, that practice in that environment was that they had the same commitment even coming from the hospital and their geriatrics clinic was in the South Shore neighborhood. We worked in a safety net nursing home in South Shore, so it was very much community based as well.

And I just think, you know, when we're talking about geriatric patients, they are such an integral part of their community and transportation is often an issue and says keeping geriatric care in the community was kind of my my goal in, you know, developing a practice at in UHC.

00;03;52;04 - 00;04;14;07

Speaker 2: Raj Shah, MD

I've always been curious like how what sort of happens in the space, some of the patient populations and especially with older adults that go to seek care and maybe you can highlight a little bit about sort of the patients that you see that are older. You know, you might be at risk for dementia in your practice. Can you can you give me a sense of who they are?

Will you see from Rogers Park?

00;04;16;24 - 00;04;39;27

Speaker 3: Emma Daisy, MD

Yeah. So I think federally qualified health centers in general, you'll see a huge diversity in the clinics if you go to different, different clinics or different locations. I've rotated through ones and one in rural West Virginia as well as different ones in Chicago, and they all have a very different flavor because they are representing their community. Each one's a little bit unique in terms of what the needs of that community are.

And one of the things I really like about Tapestry and, you know, this clinic here that you're in and Davon is just the diversity of the population. I just really love not just the socioeconomic diversity, but the cultural diversity. We've got patients from all across the globe. I mean, we're on the language line with interpretation and languages from not every single continent, but definitely north, South America, Europe, Asia, Africa.

You know, those are all covered. Sometimes we can't even get an interpreter on the line. I guess it could be frustrating if it's not now you're used to. But but I just really enjoy working with such a diverse population. And the flip side of that is we're also fairly close to Loyola. So I get the sort of diversity of of American population as well.

We've got I've get grad students, I get college students, I get the artists, waitress, musician, people from Rogers Park. So I have a lot of that as well. I have a patient whose original doctor was Doctor Clinton Young.

00;05;43;12 - 00;05;44;00

Speaker 2: Raj Shah, MD

Oh, wow.

00;05;44;10 - 00;05;58;06

Speaker 3: Emma Daisy, MD

Yeah. So we always and he's a big that Patients are big activists in terms of community organizing and rights for different populations in Chicago. So we're always talking about what it was like to to be going to Dr. Clinton. Young As your as your doctor.

00;05;58;16 - 00;06;12;29

Speaker 2: Raj Shah, MD

And maybe you want to just explain to our audience, because many may not know the history. Yes. Dr. Quentin Young and his presence in Chicago and advocacy for broader populations. But just want to give a one or two words about Dr. Young.

00;06;12;29 - 00;06;20;10

Speaker 3: Emma Daisy, MD

Yeah, he was Martin Luther King's personal physician, and he was just a big advocate for health care as a human right in Chicago.

00;06;21;00 - 00;06;47;23

Speaker 2: Raj Shah, MD

Yeah. So it's kind of your tying those histories together, which is really always a fascinating thing. And one thing I really loved about working with older adults where they can kind of bring the tapestry of time along with space that you are talking about a little bit before. So I'm kind of curious like, what are the things do you sometimes find as barriers that enough to see to being able to do that early detection and diagnosis of people maybe at risk for developing a dementia?

00;06;48;17 - 00;07;12;13

Speaker 3: Emma Daisy, MD

So I mean, I think probably most people who are working in family medicine, whether you're in an UHC or in a private practice or a hospital based practice, you're thinking the time constraints, right? Because it really doesn't matter who you're seeing right now. There's a time constraint is kind of your number one constraint. And so when you're working with older adults, obviously they need a little bit more time, they're more complex, but they also move more slowly, talk more slowly.

Often the visits just have a different cadence then than they do with your younger patients. So that's a huge barrier to care in in UHC.

00;07;21;01 - 00;07;53;06

Speaker 2: Raj Shah, MD

So can I, can I just because we have asked another podcast of this series, it kind of encouraging or seeing you like are family physicians, primary care physicians in the UHC adding components of like the annual wellness visa as a way of, you know, talking about it when you don't have as much time to be able to talk a little bit more about cognition, function, mood, how has that been working in your experience in the UHC as, as a as a way of maybe using that dynamic of the annual wellness visits to address some of the issues on cognition?

00;07;53;19 - 00;08;10;28

Speaker 3: Emma Daisy, MD

Yeah, I mean, the annual wellness visit, their memory is one of the things that you're supposed to hit in a medicare annual wellness visit. I think as a physician for UHC because of the way our payment structure is that that each visit gets paid the same amount kind of regardless of what you're doing. And that's not true with Medicare.

Medicare does we do get slightly different reimbursements, but overall, in general, it's about the same. Even doing the annual wellness visit, it's hard to fit it in one patient because nobody comes in for their annual wellness visit or come in for something else. And so even with that, I find that I'm often just trying to click off a couple of those things on the list that you're supposed to do in a regular visit.

The other thing with memory, I think, is just the understanding within the community that it's a problem, right? Because my population is very international. So I don't know how true this is across the board. But but there's a lot of folks coming in with their family members where it's not a problem until there's, you know, a barrier that they hit that they're not able to overcome.

So oftentimes that's the the citizenship civics exam in they they're studying for and they can't can't retain the information for. And so all of a sudden they're realizing that there's a problem where their cultural concept of of dementia is more that it's a part of aging and that it's not a problem. It's just sort of what happens as you get older.

00;09;14;17 - 00;09;42;09

Speaker 2: Raj Shah, MD

Yeah, I think that's like a really nice insight, right? And in dealing with the community that you serve is that there's always a different reason for why cognition comes up in a discussion. And your case that sometimes it comes up when you need the cognitive function to pass something or to do something like the citizenship examinations. So we can you can sometimes use those right as an opportunity to it's a flag.

But the other people are telling you there was an issue and now I've got to spend a little bit more time dealing with it and so so that's interesting that you will have different flags and different CS depending on the population you serve and sort of the needs for older adults in those communities and how they engage with the rest of the world and use cognitive abilities to get through it.

But I like that that that was, you know, a frame to maybe reference to people who are seeing in their UHC. It's more of an immigrant community is are they noticing difficulties with completing some of their citizenship exams or you know, and maybe that's a trigger or a way to ask it that it becomes something of meaning and not necessarily just something that, oh, I think it's just part of aging, because that's how I'd been brought up and my culture, that's where we kind of look at it.

So it would be an interesting it's an interesting dynamic you just brought up that I would have never thought about as a as a way of engaging with older adults about their cognition.

00;10;38;27 - 00;11;01;07

Speaker 3: Emma Daisy, MD

Yeah, I think trying to think a little bit more broadly, I think in all UHC is where we're taking care of a more underserved population. The caregivers are often working adults, often working jobs where they don't have any time off. So that's definitely a barrier to diagnosing things like like memory or dementia because they don't have time to bring their their older adults in.

Or if they do, it's got to be an evening appointment. And if they if they do that, you know, they really have to get in and get out. And oftentimes my older adults are coming in with grandkids who are the ones who are a little bit more flexible to be able to bring them in. And then that social dynamic, especially from other cultures of sort of deference to your elders, really kicks in that they really don't want to say about their grandparent that there might be something wrong, at least not in front of their grandparent.

00;11;26;22 - 00;11;56;18

Speaker 2: Raj Shah, MD

Yeah, that's because we do somewhat require that ancillary information to make the diagnosis of early dementia, especially when some of our tools, because of the diverse population of the need for translation, may not work as well because they were never designed in those spaces. You need informants like other people to tell you about what's been going on to corroborate, and your point that if in a very working class community, you can't get people to spend the time right to take time off, they just can't.

And how do you get that information to support your work as a clinician? So definitely time factors. It sounds like there's some factors around Just the tools we have may not be perfect as far as being able to work with diverse cultures, and we have to get better at that because we don't have great tools around diversity. We have to depend on the story that's told by multiple parties.

But that brings up sort of these dynamics that make it a little bit difficult in some of the communities we serve. I was actually also curious about your in the engagement with translational services, right, that you have to bring another person in the room with you sometimes or on the phone to have to help with, you know, accurate translation of your questions maybe around cognition or cognitive function and that person.

And then have that information translated back to say in English by this translated her. I think good translator will always do that well right as a medical translator. But I think, you know, sometimes you can't find a translator and it becomes a lot difficult.

00;12;57;21 - 00;13;14;29

Speaker 3: Emma Daisy, MD

I think it's an interesting point because I so number one, I it is something that I always use a translator for, even if it's Spanish, which I'm not fluent in, but fairly functional in and and don't always do all my

visits with a translator. But even in Spanish, I'll use a translator when we're talking about memory and when it's in Spanish.

I know whether or not they're translating well enough for what I'm trying to ask, but we get people who speak like Rohingya or Aruba or languages that I have no idea what they're saying, and I have no idea if they're translating it correctly. And you've probably experienced this in your practice, too, that the types of information that we're trying to really drill down on when we're doing a memory evaluation isn't necessarily how the the patients or their caregivers have thought about it before, right?

So you're kind of asking them to sort of evaluate in a new way what their loved one's behaviors are, what their cognitive function is. And so you really kind of do have to drill down and understand what they're saying and that, you know, when I have an interpreter who I I don't know how well they're translating versus interpreting and sort of asking the question again, which they definitely will do.

They definitely in some of those languages, because it's not like a word to word translation, there is a cultural difference. They do do that. They do sort of translator interpret more than just just translate what I'm saying and, you know, that's necessary. But then I always do kind of wonder how much is being lost through the process.

00;14;25;10 - 00;14;48;20

Speaker 2: Raj Shah, MD

Yeah. And so, so yeah, well, you've identified some of these key barriers right in your in the practice in the context of working in and see any thoughts about what you found to be somewhat effective in going through one of these cognitive evaluations or just based on your experience to date, what seems to work? Sometimes we won't have perfect solutions, but are there some solutions?

00;14;49;17 - 00;14;52;23

Speaker 3: Emma Daisy, MD

And so do you mean just in terms of like getting a memory evaluation?

00;14;52;23 - 00;15;17;10

Speaker 2: Raj Shah, MD

Yeah. Yeah. Like how do you kind of do that initial work? You know, as I said, somebody comes to you and says, Hey, look, I'm having troubles like passing the citizenship exam. I'm trying. It just I'm not absorbing this information. I'm worried that I may never get past this and I won't get my citizenship. How would you take it from there, like in your office practice To say, kind of figure out, is that depression?

Is that is it a learning disability? Is that something to really do that they're having troubles with a dementia process such as Alzheimer's disease that might be going on?

00;15;26;27 - 00;15;47;13

Speaker 3: Emma Daisy, MD

I think in dementia I was trained and oftentimes insurance kind of puts the pressure on us that you have to have an objective measure of how well they're able to function. And even in training, you want to try to get that objective measure, whether it's a marker or MSI, some kind of a score that then you can track over time, even if the number isn't as diagnostic.

The idea that you can see, okay, this is what there are now, and here's how it changes with time. But with my population, I really can't do that with a lot of them. And we've tried using something called the Root s r udas, which is designed for an international population to be done with a translator. But even with that, it gives you a number, but it doesn't really tell you anything about what that means in terms of their ability to function or what they were able to do 20 years ago versus what they're able to do now.

So really, most of it is ends up being that history from the caregiver, the family, the folks who know them best. And, you know, in my population, where we have a pretty intact family structure for a lot of my patients, that's pretty you know, I can usually do a pretty good job of drilling down and asking those questions.

But having worked in other underserved areas where there's a lot more social isolation and seniors who are living alone or seniors who are the caregivers for the family, and even as they're starting to decline, you know, in South Shore, we had a lot of grandparents who were the anchor in the family. And then the children's generation has sort of scattered or dispersed, and then they're taking care of grandkids.

So there's sort of that generation missing there. And that was a lot harder to get the information. But then also thinking about function and those other things like depression playing a role in it, that's that becomes really difficult to tease out, especially because in dementia you can get, you know, which is the cause and which is the effect.

You can get the depression as a as a result of the disease as well as as cognitive changes as a result of the depression. So part of that is, you know, the advantage of being in an age where hopefully, hopefully you have a little bit longer term in relationships with your patients, but also relationships with the family members where you're seeing them or maybe your partner is seeing them and you can sort of put together a little bit about what's going on at home.

00;17;44;21 - 00;18;10;14

Speaker 2: Raj Shah, MD

Yeah, No. And I think that's some of the key is that we forget about, right. Like we focus on some of the things that we can't do sometimes in our practice. Like that was not like our training and our or what other people have told us that we have to do. And instead of focusing on the things we have and the tools we do have, right, whether it be our brain, whether it be those connections with the community and the networks of the families, whether it be, you know, some of the other tools we can use of time.

And I think that's the precious thing we have in some of the primary care offices that you can flag that there's an issue. Right. And you can keep it there and then you can work together over time, just see what's happening. And if you think that the depression is there, you of course, you treat it right, like you treat it and then see how they do afterwards.

So there's always this nice thing about the longitudinal ity of primary care that especially if you're anchored in a community that can be built up. And that's the strength in UHC, is that we sometimes don't get at an academic center, especially a tertiary center, that does evaluations. I get one time to see that right, maybe in a year.

And I have to make that decision, you know, that there's some more of those balances. And after you age these around, I can see them again. I can follow this pattern. I can test something out and may not work out the way I thought. But then I can adjust again because I'm seeing now and gather a little bit more information over time.

So so I hope people do feel like especially are the people I value that practice, family, medicine and primary care in UHC is that there are strengths you have, right? And it's just a matter of like, how do we use them to our best ability is I think, you know, you're much better at using translators than I probably am, right?

Because it's just you have to do it a lot more in your day to day experiences and understand what the limitation are and the strengths of it. But I think we have to also convince maybe with places like our medical societies that forcing more getting more help like neuropsychological testing or something like that, and having to prove that you've done a Bogota's when they and the MOCA test wasn't designed to be given to this population.

And you really just need to depend on the information you gather in your notes about what is happening, what people with their function is good enough, right? Like it is the better tool rather than necessarily forcing us to have to check the box and say we have a MOCA exam where it might not mean anything for the population or serving.

So, you know, I've learned a lot just by talking a little bit about, you know, some of the day to day activities and practices and challenges. But maybe the solutions are also embedded and there, which is we trust what we do and what we collect and how we organize said. And we advocate that that should be good enough to keep moving forward with helping our patients.

00;20;28;26 - 00;20;56;22

Speaker 3: Emma Daisy, MD

Absolutely. Yeah. I see. I definitely feel like the relationships we develop and skate sees and and the ability that we have to bring people back is so important to being able to help diagnose, but also treat dementias. And you know, the same things that are barriers. Like the thing I know we're talking about prevention today but the same things that are barriers for diagnosis, like the different cultural perceptions of the disease and what it means are also advantages for treating it or taking care of it.

becomes, I don't want to say irrelevant, but not as important whether or not we get the diagnosis or the that they get the diagnosis, that they understand the diagnosis because they're coping and they're taking care of their loved ones. And they're they you know, they'll come back to us when they need support.

And, you know, we've got social workers that can help figure out the supports that they need within the community. But oftentimes times they're there presenting later because those supports are already in place in the in the community and the family already.

00;21;33;21 - 00;21;56;22

Speaker 2: Raj Shah, MD

Yeah. And that's part of our, you know, broader education, maybe using sort of a multisectoral approach about just how people can feel that they're connected. And when connections happen already because of social structures, some of those feelings don't come into play as much. I've always found, like even in my own practice, that the things that drive people to, it's not just their cognitive loss.

That's not the thing that people seek health for or talk to a physician about. It's usually when the cognitive loss is impacting something they want to do right? Like they're getting frustrated by something or they can't do something. And that's what drives it. And we just have to kind of help to keep our eyes and ears open for those aha moments where we can engage with people and interact and help to support them a little bit better and keep them safer.

But it does bring me to something you mentioned that comes back to the idea of the tapestry, is that, you know, the at the primary care practice at an UHC with resources such as like social workers that can engage with the community being run by a community organization that understands the community, how do we kind of work together with these multiple sectors to maybe engage?

So it's not only just the health care and the social work community or social services community, but maybe even some of the businesses that are in the area, especially around these issues. You are talking about before about I need some time, right, for my family members, maybe working in some of these businesses in the community to have that 15 minutes or 30 minutes to come to an appointment and to be with their loved one that might be going through a cognitive evaluation.

And I think you had gone to a just a broader meeting recently about how we can build, like the engagement with businesses and other community members with the health and social services. And I'm just wondering if, you know, those things are a strength maybe of the UHC and as leadership to keep advancing these dementia friendly community ideas?

00;23;29;13 - 00;23;51;00

Speaker 3: Emma Daisy, MD

Yeah, I mean, I do think that our clinic is really very much rooted in the community, right? I mean, we're a community health center, but it's true in practice that most of my referrals are word of mouth from

from folks within the community talking to each other. And, you know, most people work within the community, too. So so their employers are part of it.

And I think that that's one thing that honestly I've seen with the COVID pandemic is the importance that family plays in our lives came to the surface for everyone during the pandemic. Right. Whether it was parents taking care of their children and their children having to be at school at home, and that affecting their ability to work or people getting sick and family members having to take care of folks at home or stay home themselves.

When they were quarantining with COVID, it had a huge impact on how we interact in a work environment and in a community as a whole. And so I'm hopeful that there will be more changes in that aspect that will impacts our geriatric care as well. But honestly, it's the whole community care. We all benefit when we're thinking about ourselves that way.

00;24;36;25 - 00;25;06;24

Speaker 2: Raj Shah, MD

Yeah, and I think that and, you know, I think we were talking even before, as we were setting up, I coming up to see you about some of these, you know, how some businesses are engaged in this space. And I think we were sharing this example of a group that was involved in sort of the coffee retail business, was sort of engaging with their employees, learning about dementia concepts and supporting them as an example of how business can help a little bit with the social services, help with the medical needs and keep people from feeling stigmatized in their community.

So I was kind of curious if you wanted to relay that story. And while we were learning about or what we were talking about before we met today.

00;25;14;10 - 00;25;18;01

Speaker 3: Emma Daisy, MD

Yeah, so we were allowed to mention brand names right.

00;25;18;01 - 00;25;19;09

Speaker 2: Raj Shah, MD

Then be inspired by.

00;25;20;07 - 00;25;40;12

Speaker 3: Emma Daisy, MD

Starbucks. So it was actually a community in Japan. I can't remember the name of the town, but they were having a hard time with. In Japan. There are a lot of older people and a lot of folks who have dementia and they were coming in and it was really, you know, for all of us who've been in a Starbucks line, it gets frustrating when that line gets slowed down and it slows down pretty easily.

If you're not ready with your order and you're ready to to pick up your drink and pay and quickly. And so that was becoming kind of a problem when these folks were coming in with their caregivers, which was often happening sort of in the early afternoon when they needed a break, when things were slowing down the assembly line at Starbucks.

But they started working with that as an asset, like here's a potential customer base, right? And we're as a coffee shop, that's what we are. We promote people coming here spending some time. It's about connecting with other people. It's about enjoying your drink. So if we can engage and maintain these folks as customers, then that helps our business because we're here to sell coffee.

So they trained all their employees in how to work with folks with dementia, how to give them a little bit more time and talk to them in a way that was not demeaning and not rushed. And as a result, the community was much happier and Starbucks was much happier with their with their way their business was going.

00;26;36;26 - 00;26;55;26

Speaker 2: Raj Shah, MD

Yeah, come from interesting. You know, a little anecdote about what we could do right with a few age sees as anchors in our community, with the employees of the patient population and the community to really support this idea of dementia friendly communities. And we'd love to see like dementia friendly Rogers Park at some point. And I know, right?

But I guess, you know, we've had a great conversation. I know you've got a busy schedule also building up in your clinic today, so I really appreciate you taking this time to talk with us and be part of our podcast. But before we end, were there any other things you wanted to bring up that we might not covered and discussed today?

00;27;13;00 - 00;27;41;16

Speaker 3: Emma Daisy, MD

Yeah, I mean, I've really enjoyed talking to you today, Roz. It's it's a nice change for me to get to talk to someone with your background coming from a, you know, the, the tertiary care center, the specialty care center down at Rush and I really missed that from my my residency and my training. And I guess is there are there any good ways for for me or for other doctors who are maybe feeling like this was a good intro to get more involved in geriatric care and some, you know, more education or support resources within the IFP?

00;27;41;16 - 00;28;13;01

Speaker 2: Raj Shah, MD

Oh, that's a great question. And you know, I think we're going to have some of those resources available on the website for the brain trust and where the podcast will be hosted. But a really nice thing that's happened as one of the a few chapters in the entire nation, the Illinois Academy of Family Physicians has created a member interest group around geriatrics, and that gives us an opportunity to keep these conversations going and sharing experiences from different avenues and how we engage.

So I'd really encourage you to look at joining us as being part of that geriatrics member interest group and engaging and learning and growing together. I know people will be really interested in understanding how that happens of primary care, working with older adults and seniors and the prospective you bring. And that's the fun of just being able to talk with each other again as physicians doing different things over time.

00;28;36;14 - 00;28;46;18

Speaker 3: Emma Daisy, MD

So I love that the member interest groups, they're always changing it, reflective of our of our membership. So that's great to know that there's a geriatrics one. I'll definitely get involved.

00;28;47;03 - 00;29;12;05

Speaker 2: Raj Shah, MD

Great. Well, that brings us to the end for today and for a conversation with Dr. AMA. Day Is the Tapestry 36 Day Health really enjoyed our time in Rogers Park and we look forward to you joining us for future parts of these podcast. And if you know anybody in your community and the work you're doing in primary care to advance early detection of dementia, please be in touch with us and we'd love to talk with you.

So thank you again for being part of the show today. AMA, really appreciate it.

00;29;16;19 - 00;29;23;23

Speaker 3: Emma Daisy, MD

Thank you guys. It's been great.

00;29;23;23 - 00;29;48;21

Speaker 1: Kate Rowland, MD

Thank you to our expert faculty and to you, our listeners, for tuning in to this episode. If you have any comments, questions or ideas for future topics, please contact us at podcast at the Brain Trust dot com. For more episodes of the Brain Trust, please visit our website. The Brain Trust Project dot com You'll find transcripts, speaker disclosures, instructions to claim CME Credit and other Alzheimer's resources as well. Subscribe to this podcast series on Health Care Now Radio, Spotify, Apple, Google Play for any major podcast platform. Thank you again and we hope you tune in to the next episode of The Brain Trust.