The Power and Possibility of PASRR Webinar Series

Webinar Assistance

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For further webinar and PASRR-related assistance, contact Claris Chang (cchang@mission-ag.com).

Please note that you must attend the entirety (90 minutes) of this webinar if you wish to receive Continuing Education credits.
Dementia and PASRR

Timothy R Malloy, MD, CMD
Overview

- Impact of Alzheimer’s Disease
- Diagnostic criteria
- Dementia-related behaviors
- Interface of dementia with MI/ID
- When dementia becomes the “primary diagnosis”
Prevalence and Impact of Dementia in the US

- >60 years: 1%
- >85 years: 32% to 47% (fastest growing pop.)
- Today: About 5 million have Alzheimer’s Disease
- Fourth leading cause of death in elderly
- Third most expensive disease
- Incidence in MI/ID populations
Diagnostic Delays

- “Mom’s just getting old”
- Fear of diagnosis (families and clinicians)
- Usually 3 years of symptoms before diagnosis
- Over 50% of AD sufferers are undiagnosed
- Dementia symptoms might be mistaken for MI/ID exacerbation and cause further delay
Consequences of Delayed Dx

- Compliance with medications and appointments
- Unreliable symptom reporting (undetected, treatable medical conditions)
- Safety issues, auto accidents, environmental exposure
- Financial victimization
- Social isolation and neglect (until crisis situation)
- Missed opportunity to begin treatment at early stage
Consequences of Delayed Dementia Dx in pt.s w MI/ID

- MI/ID patients would be even more vulnerable to the harms mentioned earlier
- Doses of common psych meds may need to be much lower in dementia patients
- Dementia pt.s are more vulnerable to side effects of common psych meds
- Meds such as cogentin can make dementia related cognitive impairment worse
Risk Factors For Developing Dementia

- Advancing Age
- Family History of Dementia
- Head Injury/Concussion/TBI
- Poorly controlled HBP, DM, and Lipids
- Stroke(s)
- Alcoholism/Drug Abuse (esp in MI)
- Low Intelligence, Education, Job Level
A.D. Diagnostic Criteria

Progressive Memory Impairment

And

Impairment in at least one other cognitive area:

• Aphasia
• Apraxia
• Agnosia

or

• Executive Function (esp apathy and procrastination vs ED is MI/ID)
Diagnostic Criteria (cont’d)

- Must be progressive and at least of 6 months duration
- Must not be due to delirium
- Must not be due to MI/ID
- Must not be due to other medical condition (e.g., brain tumor)
NO...NO...
I SAI D I'VE GOT
ACUTE ANGINA
Differential Diagnosis of Alzheimer’s Disease

- Delirium
- Vascular dementia
- Dementia with Lewy Bodies & Parkinson’s
- FrontoTemporal Dementia (FTD)
- Normal pressure hydrocephalus
- Tumor (meningioma)
- Subdural hematoma
- Hypothyroidism
- Vitamin B\textsubscript{12} deficiency
- Depressive pseudodementia
  - *reason for neuroimaging
Diagnostic Work-up

Goal: To rule in Alzheimer’s Disease while excluding other causes of cognitive impairment

- History
- Neurologic Exam
- MMSE
- Lab: CBC, Chemistry/electrolyte profiles, TSH, B$_{12}$, drug levels
- CT brain (non-contrasted) unless MRI warranted

85-90% diagnostic accuracy
Neuropsychiatric and Behavioral Manifestations of A.D.

- Apathy
- Affective symptoms
- Agitation/Aggression
- Psychosis
- Pacing/wandering
- Disinhibition
- ADL loss
Order of Loss of Functions in Alzheimer’s Disease

Normal Childhood Development...

As Alzheimer’s Disease progresses...

CTTWFTDDCHCCHCEMTPF
RDALTEORECOHCHECT
WLCKDELTOHYEHOCO
SSELFORDINATES

FINANCES
EMPLOYMENT
TRANSPORTATION
FINANCES
Alzheimer’s Disease Clinical Landmarks

• 9 year life expectancy (3-20 years*)
• 1-3 years – initial symptoms until diagnosis
• 3-6 years – dx until ADL dependency
• 6-9 years – ADL dependency until death

* Range affected by comorbidities, social support systems, disease aggressiveness, etc.
A. D. Treatment: Cholinesterase Inhibitors and Memantine

- AD meds are not disease pathology modifying and certainly not a cure BUT
- They improve and slow rate of deterioration of:
  - Cognition
  - Function
  - Delays nursing home placement
  - Lessens the emergence of behavioral problems
for prompt control of

senile agitation

THORAZINE®

*Alprim® (U.S.)

"Thorazine helps control the agitated, delirious senile and help the patient to live a composed and useful life."

Smith Kline & French Laboratories
Psychotropic Meds and Dementia

• None are FDA approved for dementia indication (all off-label)
• Some have explicit warnings
• Non-pharm measures get overlooked
• PASRR recommendations might have a major role
• Even if meds necessary, “one size fits all” is a bad idea
Types of Behavioral Disturbance

- Withdrawal / Apathy
- Agitation
- Aggression (provoked / unprovoked)
- Pacing / Wandering
- Depression related symptoms
- Disinhibition
Peak Frequency of Behavioral Symptoms as AD progresses

Causes of Agitation

• Physical causes
• Situational causes
• Psychiatric comorbidities
  – depression
  – mood lability/disinhibition
  – psychosis
Physical Causes of Agitation

- Pain - inadequate control
- Temperature - too cold
- Hunger
- Toileting need - urgency, constipation
- Noise level
- Acute illness (including delirium)
The party had been going splendidly—and then Tantor saw the ivory keyboard.
Situational Anxiety as Cause of Behavioral Disturbance

- Weekly bath
- Catheter change
- Visits by dentist, podiatrist, etc.
- 0.5 mg Ativan or Xanax 1 hour before situation
Depression as Cause of Behavioral Disturbance

• Affects 1/4 to 1/3 of long term care residents
• Pervasive or prominent dysphoria or anhedonia
• The dementia patient with depression tends to be less animated about affective sx.s. with more somatic focus esp pain c/o; whereas,
• Depressed pt.s w/o dementia will often be more descriptive about the sadness, feelings of guilt, loss, anhedonia, suicidal ideation etc
Frontal Lobe Disinhibition

- Mood lability or inappropriate affect
- Poor impulse control
- Episodically aggressive
- Perseverative
- Restless/grabbing
- Sexually inappropriate
Don't Let It Go To Your Head Mack... Her Spoon Just Slipped!
Psychosis in Dementia as Cause of Agitation

• Dementia psychosis usually delusional in nature and rudimentary/simple:
  • Spousal infidelity
  • Fear that people out to hurt them (poison)
  • People are stealing my things (losing things)
  • Strangers are in my house
  • Visual hallucinations uncommon (except DLB and PD)
• In contrast to MI related delusions being more elaborate, grandiose, and complex
Medication Should Be Directed at Specific Target Behavior

- Depression – antidepressant, mood stabilizer
- Mood lability - mood stabilizer
- Situational anxiety – scheduled anxiolytic
- Psychosis – antipsychotic

The more obvious the behavior fits a target, the easier the choice of treatment
Keys to Diagnosing Dementia in folks with MI/ ID

• There must be a clear decline from a previously established baseline level of
  – Cognitive abilities
  – Functional abilities
  – Behavioral issues
  – Not necessarily all of the above
Diagnostic Challenges when Co-morbid MI/ID occurs

- Is the Executive Dysfunction due to MI/ID or to an evolving dementia?
- Are the psychotic symptoms due to MI/ID or an evolving dementia?
- A well defined baseline is essential
- Sometimes only time will tell because dementia always progresses
Diagnosing Dementia in Down’s Syndrome might involve:

- Loss of ability to perform job duties
- Difficulty learning new information or tasks
- Exaggeration of personality traits (disinhibition) or a decrease (apathy)
- New onset incontinence or other ADL dependency
- New onset seizures (10% of dementia pop.)
Diagnosing Dementia in Down’s Syndrome (cont’d)

- Deterioration of language and social skills
- Deterioration of personal hygiene
- Loss of ability to experience pleasure and take part in fun activities
- But the question should always be “is this a change from baseline”?
- Baseline knowledge is therefore essential
Whether a resident is appropriately placed in a NF?

- Is altogether different than if “primary diagnosis” status per PASRR is appropriate
- PASRR did not intend for the dementia diagnosis to eclipse co-morbid MI/ID
- MI/ID might continue to prominently impact the resident with dementia in the NF
- NF placement is often a function of the social support systems and financial status of the dementia patient and has little to do with PASRR and “primary diagnosis”
PASRR Definition of “Primary Diagnosis”

- When the dementia had advanced to such a degree that the resident is unable to benefit from specialized services
- How is that determined?
- At what point in the progression of dementia?
- Easy to determine at the extremes of dementia
- There aren't clear cut answers for the grey area that exists between extremes (only clues)
How to Determine when Dementia as “Primary Diagnosis” has occurred

• A cut off point on the MMSE?
• Functional decline to the point of basic ADL dependence?
• The level of aphasia?
• The level of apraxia?
• The level of agnosia?
• Are any chronic symptoms of the MI still present or have they been eclipsed by the dementia?
Has Dementia become the “Primary Diagnosis”? (cont’d)

• When the answer is elusive, the solution might be to have a trial of specialized services

• Reevaluate at a later date
Case Example

- 68 yo with schizophrenia and Diabetes in ALF
- Cognitive decline over past year characterized by
  - Apathy
  - Hygiene deterioration
  - Incontinence
  - Reclusiveness
  - Language skills deterioration
- Developed foot ulcer and refused to take off shoes to allow cares
- Exceeded scope of ALFs ability to provide care so transferred to NF
Case Example (cont’d)

- Was NF placement appropriate?
- Is Dementia the “primary diagnosis”?
- Doesn’t she still have Schizophrenia?
- Would specialized services improve her Quality of Life?
Case Example (cont’d)

- Is she aphasic to the point of no longer being able to communicate? No
- Is she so apractic that she can no longer carry out some tasks alone or even with assistance? No
- Does she recognize familiar people or things (agnosia)? Yes
Case Example (cont’d)

• Does she have paranoia related to her MI that isn’t optimally addressed?
• Is undiagnosed depression or delirium a contributor to her decline?
• A hard look at some of these questions might help make the determination.
• A trial and a periodic re-look might be appropriate.
Clues that MI/ID still there?

- The presence of coexisting delirium further clouds the picture
- The characteristics of psychosis might offer a clue that mental illness is still relevant
Is Delirium Part of the Picture?

- Important evidence of delirium: Lethargy and Inattentiveness.
- Delirium is common in folks with dementia and often unrecognized.
- Co-existing delirium will make screening even more difficult.
- Better to screen patients once delirium resolved and new baseline achieved.
Psychosis in MI/ID vs Dementia

• Visual hallucinations are uncommon in AD but common in DLB/PD.
• Auditory hallucinations are uncommon in all dementias.
• Both auditory and visual hallucinations are common in folks with mental illnesses.
• The usual psychosis seen in Dementia is delusions of a paranoid type (not complex or grandiose).
Psychotropic Medication for Persons with both Mental Illness and Dementia

Some medications typically given for MI may need to be used differently for persons with a co-occurring dementia.

- Use lower doses of….
- xyz class of meds harm this and that in persons with dementia
Folks with MI/ID get Dementia. Dementia doesn’t necessarily eclipse the MI/ID. Sometimes hard to discern whether the MI/ID is still relevant. Knowledge of the cognitive, functional, and behavioral symptoms of dementia can help you make that determination.
Networking with NAPP
(National Association of PASRR Professionals)
http://www.pasrr.org/about.aspx

- Networking with NAPP is a follow up discussion on the webinar.
- The next Networking with NAPP session is:

  Tuesday, January 27th, 2014
  1 PM EST

  To register for the session, please contact Betty Ferdinand: (bferdinand@ciius.com).
  A reminder invite will be sent to all webinar participants.