



mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

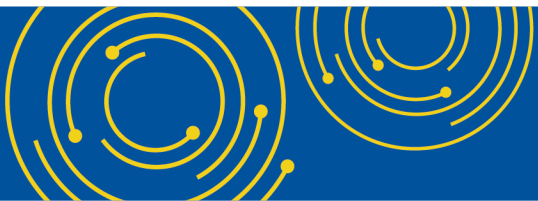
National Partnership to Improve Dementia Care in Nursing Homes & Quality Assurance and Performance Improvement

March 23, 2021



Acronyms in this Presentation

- ADL: Activities of Daily Living
- BPSD: Behavioral and Psychological Symptoms of Dementia
- CMS: Centers for Medicare & Medicaid Services
- EMR: Electronic Medical Record
- GDR: Gradual Dose Reduction
- GSA: The Gerontological Society of America
- IPA: International Psychogeriatric Association
- PCP: Primary Care Provider



Residents with Dementia-related Psychosis: Strategies for Evaluation and Care

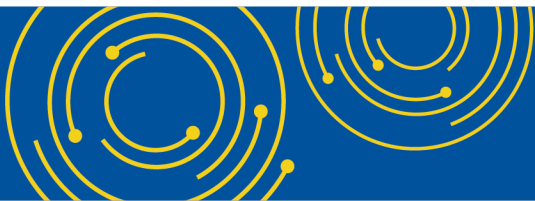
Presenters:

Alexis Eastman, MD

George T. Grossberg, MD

Susan Scanland, MSN, CRNP, GNP-BC

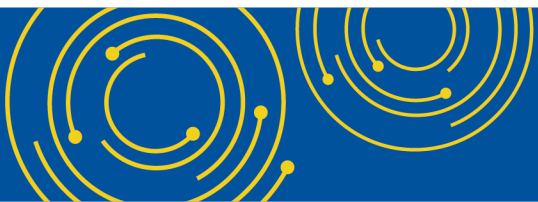
Chad Worz, PharmD, BCGP



Presenters

Members of The Gerontological Society of America's (GSA) Workgroup on Dementia-related Psychosis (in order of presentations):

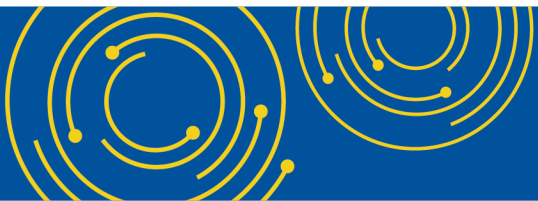
- **George T. Grossberg**, MD, Samuel W. Fordyce Professor and Director of Geriatric Psychiatry, the Department of Psychiatry and Behavioral Neuroscience, St. Louis University School of Medicine
- **Alexis Eastman**, MD, Medical Director, Division of Geriatrics, UW Hospitals and Clinics and Assistant Professor, University of Wisconsin School of Medicine and Public Health
- **Susan Scanland**, MSN, CRNP, GNP-BC, CEO & Founder, Dementia Connection® Clarks Summit, PA
- **Chad Worz**, PharmD, BCGP, Executive Director and Chief Operating Officer of the American Society of Consultant Pharmacists



Disclosures

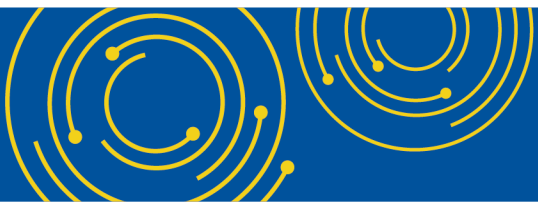
Members of GSA Workgroup on Dementia-related Psychosis (in order of presentations):

- **George T. Grossberg**: Consultant for Acadia, Alkahest, Allergan, Avanir, Biogen, Bioxcel, Genentech, Karuna, Lundbeck, Novartis, Otsuka, Roche & Takeda. Member of Safety Monitoring Committee for EryDel, Newron & Anavex and the Data Monitoring Committee for ITI Therapeutics.
- **Alexis Eastman**: None
- **Susan Scanland**: Consultant and speaker for Acadia Pharmaceuticals Inc., speaker for Teva Pharmaceutical Industries, Ltd.
- **Chad Worz**: None



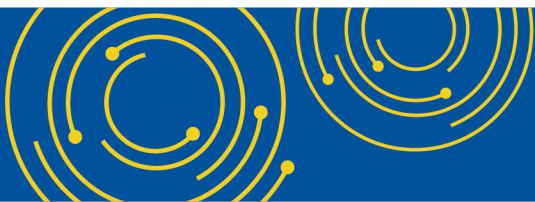
Agenda

1. Dementia-related Psychosis: Definition and Diagnosis
2. Case Study on Making an Accurate Diagnosis
3. Dementia-related Psychosis in Long-term Care: Care Strategies
4. Tips for Documentation and Ongoing Monitoring
5. Question & Answer Session



Learning Objectives

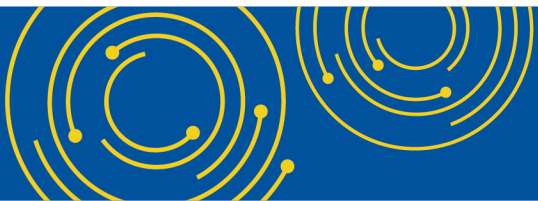
1. Understand the clinical definition of dementia-related psychosis, including hallucinations and delusions, and how it is diagnosed
2. Recognize signs and symptoms of dementia-related psychosis in residents and how to intervene in a timely manner
3. Know when to communicate with family and residents during care management
4. Understand options for non-pharmacologic approaches
5. Be introduced to evidence on pharmacologic approaches
6. Be able to apply best practices in documentation and ongoing monitoring of residents



Part A. Dementia-related Psychosis: Definition and Diagnosis



George T. Grossberg, MD



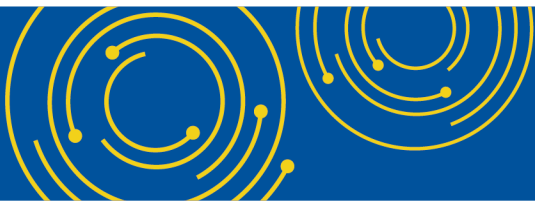
Symptoms of Dementia-related Psychosis

- **Delusions** (false beliefs)
- **Hallucinations** (seeing or hearing things that others do not)
- **Incoherent or nonsense speech** and behavior that is inappropriate for the situation
- **Loss of insight** when individual interacts with hallucinations

McKhann GM, Knopman DS, Chertkow H, et al. The diagnosis of dementia due to Alzheimer's disease: recommendations from the National Institute on Aging–Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimer's Dement*. 2011;7(3):263–269.

Weamer EA, DeMichele-Sweet MA, Cloonan YK, et al. Incident psychosis in subjects with mild cognitive impairment or Alzheimer's disease. *J Clin Psychiatry*. 2016;77(12):e1564–e1569.

Ballard C, et al. The prevalence and phenomenology of psychotic symptoms in dementia sufferers. *Int J Geriatr Psychiatry*. 1995;10(6):477-485.



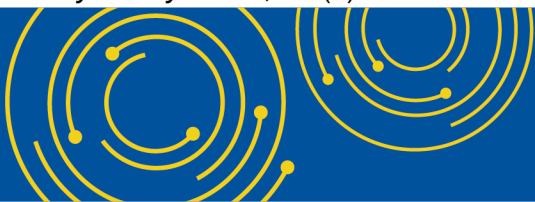
Symptoms of Dementia-related Psychosis

- Can be **frequent**: Most older adults with hallucinations and delusions in dementia experience these symptoms 2 to 6 times per week (Ballard et al., 1995)
- Are **episodic** in nature (Levy et al., 1996)
- Can be **persistent** (van der Linde et al., 2016):
 - Hallucinations: up to 52 percent of patients with persistence greater than 3 months
 - Delusions: up to 82 percent of patients with persistence greater than 3 months
- If untreated, symptoms **can worsen over time**

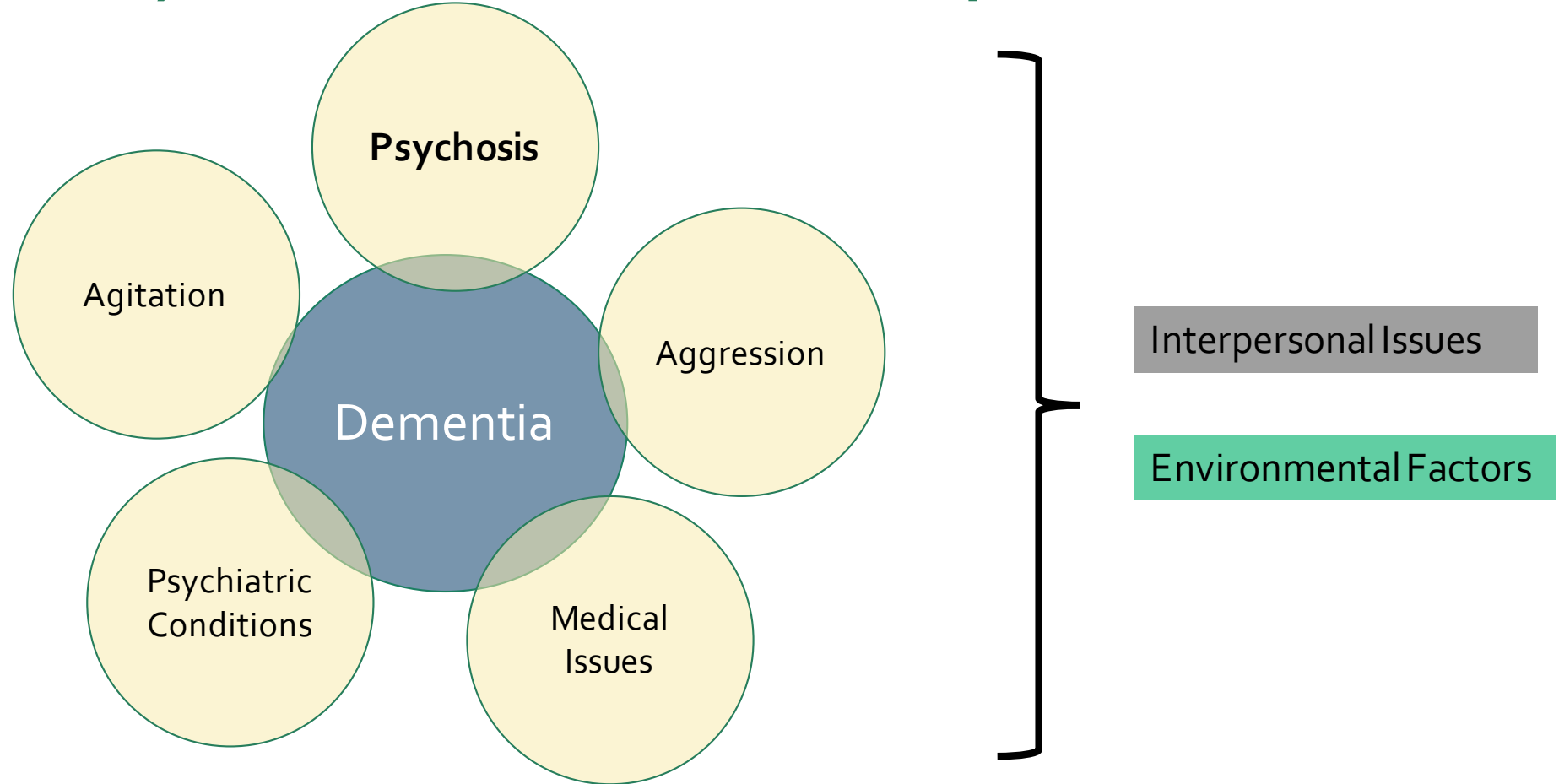
Ballard C, et al. The prevalence and phenomenology of psychotic symptoms in dementia sufferers. *Int J Geriatr Psychiatry*. 1995;10(6):477-485.

Levy ML, Cummings JL, Fairbanks LA, Bravi D, Calvani M, Carta A. Longitudinal assessment of symptoms of depression, agitation, and psychosis in 181 patients with Alzheimer's disease. *Am J Psychiatry*. 1996;153(11):1438-1443. doi:10.1176/ajp.153.11.1438

van der Linde RM, Denning T, Stephan BC, Prina AM, Evans E, Brayne C. Longitudinal course of behavioural and psychological symptoms of dementia: systematic review. *Br J Psychiatry*. 2016;209(5):366-377. doi:10.1192/bjp.bp.114.148403

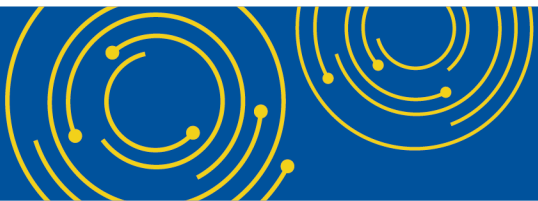


Dementia-related Psychosis, Behavioral & Psychological Symptoms of Dementia (BPSD)*, Other Conditions Overlap and Interact



*Behavioral and psychological symptoms of dementia include apathy, psychosis, depression, disturbed sleep, “sundowning,” aggression, and agitation.

Cerejeira J, Lagarto L, Mukaetova-Ladinska EB. Behavioral and psychological symptoms of dementia. *Front Neurol*. 2012 May 7;3:73. doi: 10.3389/fneur.2012.00073.

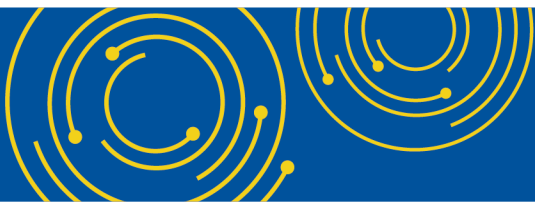


Prevalence of Dementia-related Psychosis

- Affects about 2.4 million people in the United States
- Dementia-related psychosis occurs in greater than 1/2 of patients during the course of their disease
- The prevalence of psychosis depends on the underlying disease:

Type of Dementia	Estimated Number with Dementia in US	Hallucination Prevalence (Range, %)	Delusion Prevalence (Range, %)
Lewy Body	430,000	55-78	40-57
Parkinson's Disease	320,000	32-63	28-50
Alzheimer's	5,800,000	11-17	10-39
Vascular	1,600,000	5-14	14-27
Frontotemporal	80,000	1.2-13	2.3-6

The Gerontological Society of America. [Dementia-Related Psychosis: Gaps and Opportunities for Improving Quality of Care](#). Report. August 2019.

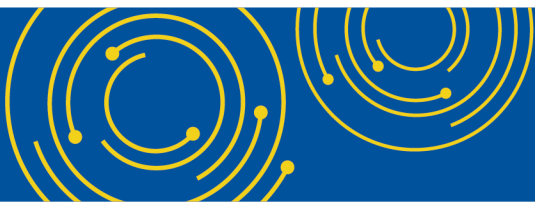


New Clinical Definition of Dementia-related Psychosis

- International Psychogeriatric Association (IPA) workgroup recently published changes to Jeste and Finkel criteria:

A. Characteristic Symptoms	B. Primary Diagnosis	C. Chronology of Symptom Onset	D. Duration and Severity
Presence of 1 or more of the following symptoms: -Visual or auditory hallucinations -delusions	All criteria for dementia are met	Evidence from patient history indicates that the symptoms defined in A have not been present prior to diagnosis of dementia	Symptoms defined in A have been present at least intermittently for 1 month or longer and severe enough to disrupt functioning

Cummings J, Pinto LC, Cruz M, Fischer CE, Gerritsen DL, Grossberg GT, Hwang TJ, Ismail Z, Jeste DV, Koopmans R, Lanctot KL, Mateos R, Peschin S, Sampaio C, Tsuang D, Wang H, Zhong K, Bain LJ, Sano M. Criteria for Psychosis in Major and Mild Neurocognitive Disorders: International Psychogeriatric Association (IPA) Consensus Clinical and Research Definition. *Am J Geriatr Psychiatry*. 2020 Dec;28(12):1256-1269. doi: 10.1016/j.jagp.2020.09.002.

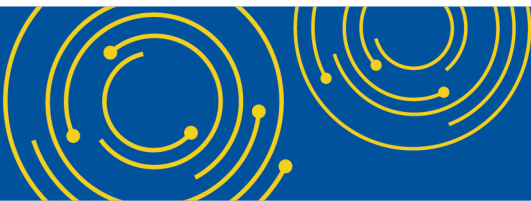


New Clinical Definition of Dementia-related Psychosis

- IPA workgroup recently published changes to Jeste and Finkel criteria:

E. Exclusion of Schizophrenia and Related Psychotic Disorders Have never met criteria for schizophrenia, schizoaffective disorder, or mood disorders with psychotic features	F. Relationship to Delirium The disturbance does not occur exclusively during the course of delirium	G. Exclusion of Other Causes of Psychotic Symptoms Disturbance is not better accounted for by another medical condition or effects of a substance	Associated Features Specify if disturbance is associated with: -agitation -negative symptoms -depression
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Cummings J, Pinto LC, Cruz M, Fischer CE, Gerritsen DL, Grossberg GT, Hwang TJ, Ismail Z, Jeste DV, Koopmans R, Lanctot KL, Mateos R, Peschin S, Sampaio C, Tsuang D, Wang H, Zhong K, Bain LJ, Sano M. Criteria for Psychosis in Major and Mild Neurocognitive Disorders: International Psychogeriatric Association (IPA) Consensus Clinical and Research Definition. *Am J Geriatr Psychiatry*. 2020 Dec;28(12):1256-1269. doi: 10.1016/j.jagp.2020.09.002.



Outcomes for Residents with Dementia-related Psychosis

- Predictive of **progression to long-term care setting and mortality** (Magni et al., 1996)
- When hallucinations and delusions are present, individuals have **significantly greater rates of cognitive decline and functional decline** (difficulty with Activities of Daily Living (ADLs)) (Karamah et al., 2019)
- Can be **highly distressing** for both persons with dementia and their care partners (Donaldson et al., 1998)
- **Negatively impacts quality of life** and personal relationships. (Brandt et al., 2020)
- **Over 2/3 of professional caregivers report emotional exhaustion** (Duffy et al., 2005)

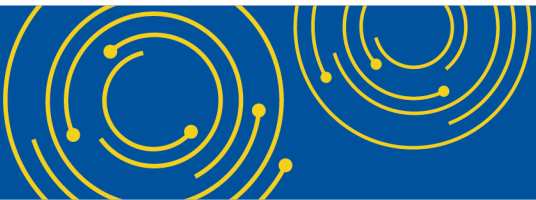
Magni E, Binetti G, Bianchetti A, Trabucchi M. Risk of mortality and institutionalization in demented patients with delusions. *J Geriatr Psychiatry Neurol.* 1996;9(3):123–126. doi: 10.1177/089198879600900303

Karamah WK, Murari G, Schweizer TA, Munoz DG, Fischer CE. Psychosis in neurodegenerative disorders: recent developments. *Curr Opin Psychiatry.* 2019;32(2):117–122. doi: 10.1097/YCO.0000000000000476

Donaldson C, Tarrier N, Burns A. Determinants of carer stress in Alzheimer's disease. *Int J Geriatr Psychiatry.* 1998;13(4):248-256. doi:10.1002/(sici)1099-1166(199804)13:4<248::aid-gps770>3.0.co;2-0

Brandt T, Frangiosa T, Biggar V, Taylor A, Keller B, Abler V. Dementia-related psychosis symptoms and impact from the patient and care partner (caregiver) perspective: an observational, prospective study to describe the patient experience. Presented virtually at: Alzheimer's Association International Conference 2020. Poster 47164.

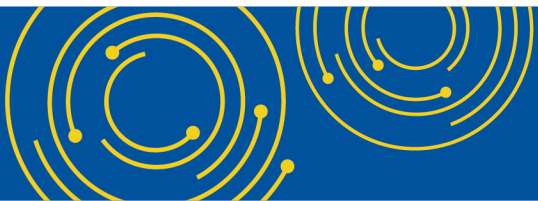
Duffy B, Oyebode JR, Allen J. Burnout among care staff for older adults with dementia: The role of reciprocity, self-efficacy and organizational factors. *Dementia.* 2009;8(4):515-541. doi:10.1177/1471301209350285



Part B. Case Study on Making an Accurate Diagnosis

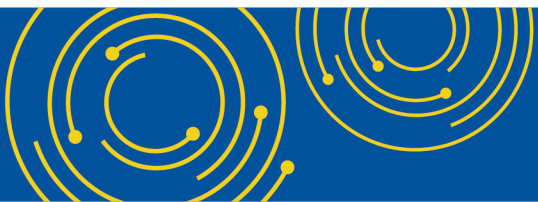


Alexis Eastman, MD



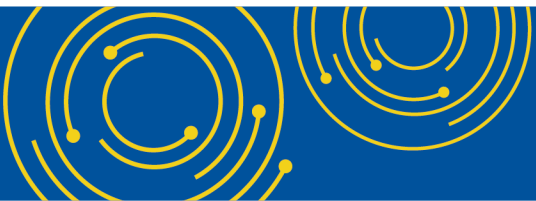
Case Study: Mrs. Jones, a Resident Experiencing Psychosis

- 87-year old female with hypertension, hypothyroidism, late-onset Major Neurocognitive Disorder, probable Alzheimer's disease
- Lives at Sunnycreek Skilled Nursing Facility; Previously cared for at home by husband, who is her healthcare power of attorney
- At baseline, she is very sociable, interacts with staff, regularly attends ice cream socials to socialize with other residents
- In the past 6 weeks, she repeatedly claims to see a strange man in her room, usually in the evenings, rummaging through her belongings and stealing things. Staff have confirmed that there is no one entering or exiting the room when Mrs. Jones claims to see a man, and family confirms she has no history of past trauma that might trigger these episodes. Because of these 'visits', Mrs. Jones is in a continually frightened state and cannot be reassured
- Last week, she claimed to see the same man outside dining room window and threw plate of food at him
- Staff calls husband and arranges for the resident's Primary Care Provider (PCP), Dr. Price, to visit Mrs. Jones



Case Study: PCP Examines Mrs. Jones

- During the visit, Dr. Price sees a very different Mrs. Jones than she is used to:
 - Anxious;
 - Avoids eye contact;
 - Fidgets and is physically restless; and
 - Talks to someone in the corner of the room who isn't there
- Dr. Price reviews Sunnycreek's chart:
 - Vitals and weights appear fine
 - Limited notes about Mrs. Jones' hallucinations and the non-pharmacologic approaches tried by staff
- Dr. Price reviews medications:
 - Appropriate dose of Angiotensin-converting-enzyme inhibitor, thyroid medication, and a cholinesterase inhibitor
 - No recent use of PRN medications (e.g., sedative, antihistamine)
- Dr. Price considers possible environmental and physical triggers:
 - Light/shadows in Mrs. Jones' room, external noise, unmet needs (hunger, pain, toileting)



Case Study: PCP Conducts Diagnostic Evaluation

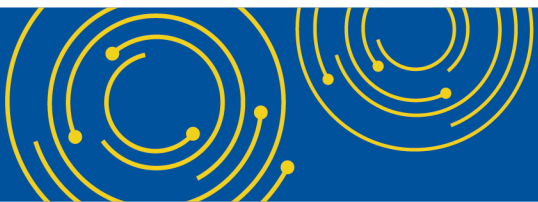
1. Dr. Price reviews medical history:

- Dementia, probable Alzheimer's disease type, hypothyroidism
- Husband reports no hallucinations in the past

2. In consult with the nursing home pharmacist, Dr. Price reviews current medications to identify possible medication side effects from potentially inappropriate medications in individuals with dementia, including those listed in the The American Geriatrics Society Beers Criteria®:

- E.g., anticholinergics, benzodiazepines, sedative hypnotics, and antipsychotics

3. Conducts physical exam to identify underlying medical conditions causing delirium such as infections (e.g., urinary tract infection, upper respiratory infection), as well as pain



Case Study: PCP Conducts Diagnostic Evaluation

4. Dr. Price obtains the following labs (which were negative):

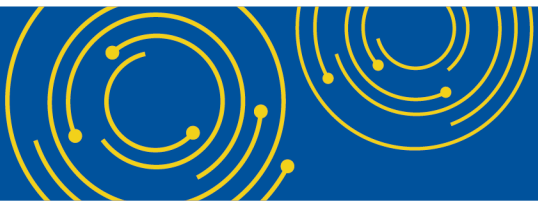
- Complete metabolic panel
- Complete blood count
- Thyroid stimulating hormone test
- Urinalysis

Dr. Price concludes that Mrs. Jones' current medications are safe and there is no evidence of delirium

5. Differentiates from other clinical syndromes which may present with hallucinations and delusions (e.g., delirium, schizophrenia, psychotic depression)

- Careful evaluation of timing, course, prior psychiatric history, potential inciting events, other signs/symptoms)

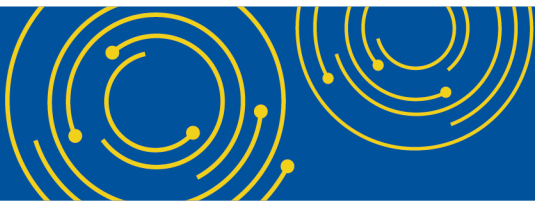
6. Result of comprehensive evaluation: Mrs. Jones' hallucinations/psychosis are due to her dementia



Part C. Dementia-related Psychosis in Long-term Care: Evidence-based Care Strategies



Susan Scanland, MSN, CRNP, GNP-BC

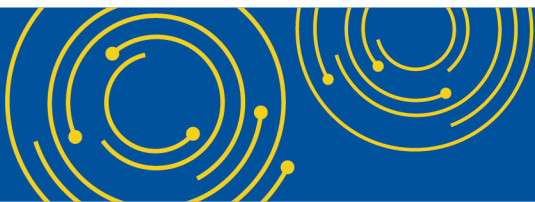


Case Study: Use of Non-pharmacologic Strategies

- Dr. Price advises staff to add non-pharmacological approaches to Mrs. Jones' individualized care plan to alleviate the anxiety caused by the hallucinations.
 - Staff creates a playlist with Mrs. Jones' favorite Frank Sinatra and Dean Martin songs.
 - Unit nurse manager encourages staff to use Validation Therapy to communicate with Mrs. Jones when her hallucinations are present.
 - CNAs start lavender aromatherapy early each evening and offer hand massages at bedtime.
- Systematic reviews of non-pharmacologic interventions for BPSD reveal music therapy and formal communication techniques impact physical, verbal, and ADL-related agitation in dementia (Dyer et al., 2018; Abraha et al., 2017). Many other non-pharmacological techniques have been helpful; despite lack of strong evidence in research (Validation Therapy, reminiscence, aromatherapy, massage and others).

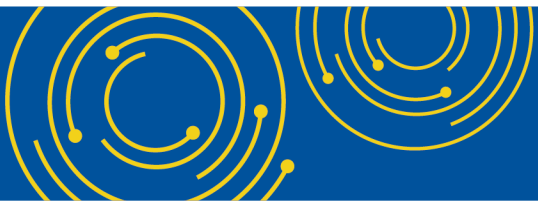
Dyer SM, Harrison SL, Laver K, Whitehead C, Crotty M. An overview of systematic reviews of pharmacological and non-pharmacological interventions for the treatment of behavioral and psychological symptoms of dementia. *Int Psychogeriatr*. 2018;30(3):295-309. doi:10.1017/S1041610217002344

Abraha I, Rimland JM, Trotta FM, et al. Systematic review of systematic reviews of non-pharmacological interventions to treat behavioural disturbances in older patients with dementia. The SENATOR-OnTop series [published correction appears in *BMJ Open*. 2017 Jul 17;7(7):e012759corr1]. *BMJ Open*. 2017;7(3):e012759. Published 2017 Mar 16. doi:10.1136/bmjopen-2016-012759



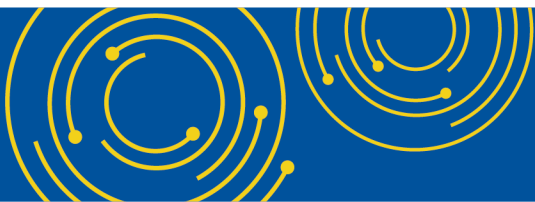
Case Study: Use of Non-pharmacologic Strategies

- Music playlists and Validation Therapy improve Mrs. Jones' daytime behaviors moderately over the next week.
- Despite aromatherapy and bedtime hand massages, night-time psychosis worsens:
 - Visual hallucinations of people in her room who are now carrying knives
 - Delusion that her mother is still alive (now crying out for her help)
 - Delusions that staff are strangers trying to poison her with evening medication
- At 3:00 am, staff find Mrs. Jones screaming that she needs to escape from the “knife people.” Despite attempts by staff to calm her with non-pharmacologic approaches, she remains distressed.
- Staff call Dr. Price to inform her that Mrs. Jones' hallucinations and delusions are worsening, and that non-pharmacologic strategies have not significantly affected her condition and quality of life.



Case Study: Use of Pharmacologic Therapy

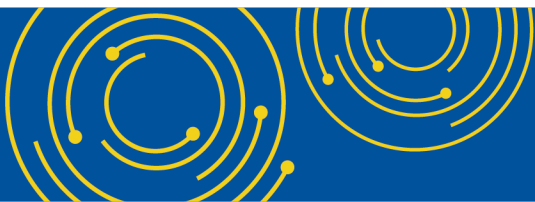
- Dr. Price recommends starting Mrs. Jones on an atypical antipsychotic.
- Dr. Price educates the staff about the need to continue to provide and monitor the medication since impact on delusions and hallucinations usually takes several days.
- The hallucinations appear to decrease and Mrs. Jones seems less distressed. Now that she is on the medication, she is more responsive to music calming her. She looks forward to hand massages at bedtime and relaxes until she falls asleep with the lavender aromatherapy.
- Staff document in their log that after a week, episodes of Mrs. Jones seeing shadowy, threatening figures has decreased by 50 percent.



Case Study: Use of Pharmacologic Therapy

- Dr. Price discusses with Mr. Jones the risk-benefit ratio of continuing his wife on the atypical antipsychotic. Dr. Price reviews black box warning for current atypical antipsychotics which includes increased risk of mortality.
- After 5 months of observation and documentation, Mrs. Jones ceases to have delusions and hallucinations.
- Given this and concerns about side effects, Dr. Price gradually begins a Gradual Dose Reduction (GDR) of the atypical antipsychotic.
- Dr. Price informs nursing staff of Mrs. Jones' care plans. Staff will continue to monitor for potential reoccurrence of hallucinations and delusions (Devanand et al., 2012) and will document these in the Electronic Medical Record (EMR).

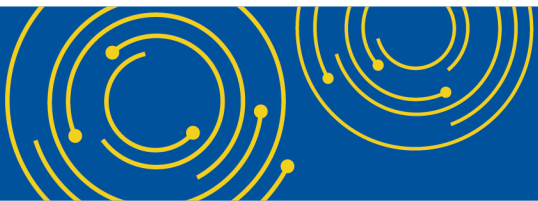
Devanand DP, Mintzer J, Schultz SK, et al. Relapse risk after discontinuation of risperidone in Alzheimer's disease [published correction appears in N Engl J Med. 2012 Dec 20;367(25):2458]. *N Engl J Med.* 2012;367(16):1497-1507. doi:10.1056/NEJMoa1114058



Part D. Tips for Documentation and Ongoing Monitoring



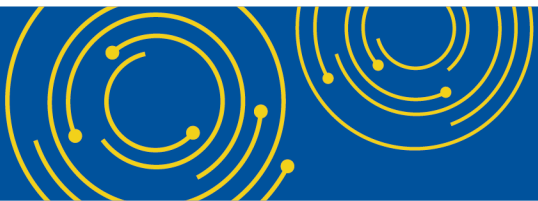
Chad Worz, PharmD, BCGP



Documentation of Provision and Effectiveness of Care

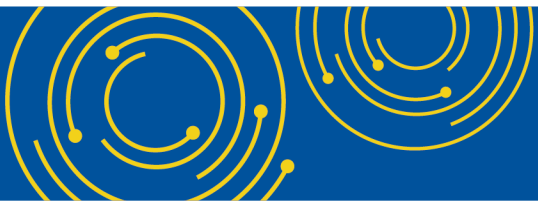
- Documentation underpins the treatment rationale for residents in skilled nursing facilities as well as in other health care environments
- **What is not documented, is not done**
- Documentation is important in demonstrating effectiveness of person-centered interventions, limited evidence exists for specific non-pharmacologic interventions but the relative safety and importance of them as first steps in person-centered approaches to care is clear (AHRQ 2020)
- Due to the nature of BPSD and the mixed evidence about the safety and efficacy of psychoactive medications, documentation is **important in demonstrating effectiveness of care**:
 - Careful tracking of changes in behavior
 - GDR (two attempts in the first year)
 - Documented clinical indications or evidence of use for psychoactive medications

Agency for Healthcare Quality (AHRQ). [Care Interventions for People Living with Dementia and Their Caregivers](#). Systematic Review. August 31, 2020.



Tips for Documentation

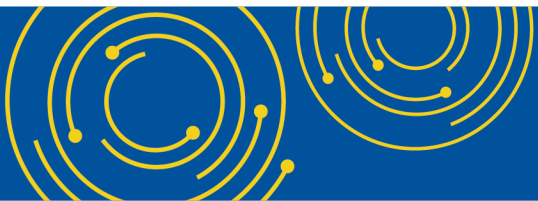
- The priority is to **have a plan** and to add interventions to the resident's individualized care plan
- **Use multiple disciplines** in the planning and ongoing monitoring process for the use of non-pharmacologic approaches to care, as well as medications in residents with dementia experiencing psychosis and/or agitation
- **Set appropriate expectations** regarding impact of medication with resident and family



Tips for Documentation

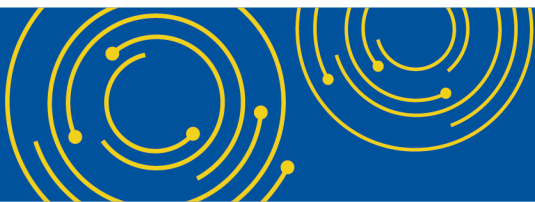
Need to appropriately document:

1. **Current care environment and medication regimen is free of triggers that contribute to symptoms** or the condition being addressed
2. **Rationale** underlying why both pharmacologic and non-pharmacologic approaches may be used or maintained
 - Allowance that it could be a chronic and/or progressive condition that requires ongoing treatment
3. **Objective clinical benefits:** progression/frequency of targeted symptoms
4. **Objective clinical adverse risks:** progression/frequency of specific adverse effects

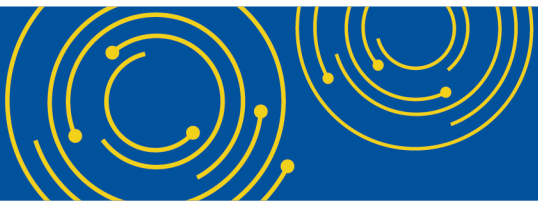


Tips for Ongoing Monitoring

- Recognize and understand signs and symptoms of psychosis documented in the medical record and Minimum Data Set
- **Document changes over time** in the EMR specific to the use of each psychoactive medication (antipsychotics)
- Continually **communicate with family** about any adjustments to medication regimen and changes in resident's condition
- **Continually evaluate and document the safety and efficacy** of non-pharmacologic approaches to care and each psychoactive medication, as well as the ongoing treatment plan
 - Use of multiple psychoactive medications and impact on GDR schedule
 - Use of evidence-based medications without U.S. Food & Drug Administration-approved indications
 - When GDR is clinically contraindicated:
 - Chronic, progressive disease
 - Resident is considered at risk
 - When GDR increases clinical symptoms/issues (failed GDR)



Question & Answer Session



Resources

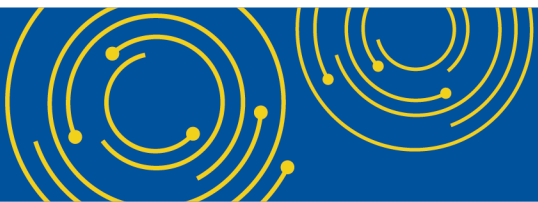
For any questions to the presenters, please email Judit Illes, BCL/LLB, MS, Director of Strategic Alliances, GSA at jilles@geron.org

Documentation Resources:

- See tips for coding dementia-related psychosis (dementia-related hallucinations and delusions) at Appendix on page 22 of The Gerontological Society of America. [Dementia-Related Psychosis: Strategies to Address Barriers to Care Across Settings](#). White Paper. February 2021.
- See CMS resource on “Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway” at [Long-term Care Survey Critical Element Pathways](#)

Additional GSA Publications:

- The Gerontological Society of America. [Dementia-Related Psychosis: Gaps and Opportunities for Improving Quality of Care](#). Report. August 2019.



Thank You – Please Evaluate Your Experience

Share your thoughts to help us improve – [Evaluate](#) today's event

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- [Medicare Learning Network](#) homepage for other free educational materials for health care professionals
- [National Partnership](#) webpage for more information about the National Partnership

Contact the National Partnership:

- dnh_behavioralhealth@cms.hhs.gov

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