Managing Psychoactive Medications in Dementia Patients

July 30, 2014
9 – 11 am

Des Moines University
3200 Grand Avenue
Des Moines, IA 50312
Purpose

The purpose of this activity is to educate attendees on the use of psychoactive medications for nursing home and assisted living residents with dementia. By sharing the research on the effect of psychoactive medications on this population, we hope to clearly communicate the dangers associated with using certain types of psychoactive medications in dementia patients. We will offer non-pharmacological approaches and tools to manage the behaviors frequently experienced by people with dementia. By reducing psychoactive medications for our dementia residents, we expect to see increased alertness, reduced fall risk, and possibly delays in cognitive decline.

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
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<tbody>
<tr>
<td>9 am</td>
<td>Memory Support Services Improvement Initiative</td>
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<tr>
<td>9:40 am</td>
<td>Facts and Research on Dementia Care</td>
</tr>
<tr>
<td>10:20 am</td>
<td>Future of Dementia Care</td>
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<tr>
<td>11 am</td>
<td>Adjourn</td>
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Speakers

- Robert Bender, MD, Geriatric Medicine and Memory Center, Broadlawns Family Health Center
- Susan Johnson, Director of Process, Improvement, Wesley Life
- Heidi Long, Director of Health and Wellbeing, Wesley Life
- Yogesh Shah, MD, FAAFM, Associate Dean, Global Health, Des Moines University

*Relevant to the content of this CME activity, the speakers indicated they have nothing to disclose.*

Objectives

- Share current trends of psychoactive medication use for memory support residents
- Discuss tools available to manage behaviors
- Share success stories from communities with low psychoactive medication usage
- Facilitate discussion on setting targets for psychoactive medication use reduction

Continuing Education Credit

ACCME: This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Iowa Medical Society (IMS) through joint sponsorship of Des Moines University (DMU) and Wesley Life. DMU is accredited by the IMS to provide continuing medical education for physicians. DMU designates this live activity for a maximum of 2.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AOA: This activity has been planned and implemented in accordance with the essential areas and policies of the American Osteopathic Association (AOA) through the joint sponsorship of Des Moines University (DMU). DMU and the AOA approve this educational activity for a maximum of 2.0 hours of AOA Category 2-A CME credit.

IBON: Des Moines University Continuing Medical Education is Iowa Board of Nursing approved provider #112. This live activity has been reviewed and approved for 2.4 continuing education contact hours. No partial credit awarded.

Other: This live activity is designated for 2.0 AMA PRA Category 1 Credits™.
Memory Support Services Improvement Initiative at WesleyLife

Susan Johnson
Director of Process Excellence
WesleyLife

WesleyLife: Who We Are

- Christian-inspired
- Not-for-profit
- 67-year reputation as high-quality provider and employer
- Dedicated workforce of 1,400
- Serving nearly 7,000 older adults this year -- wherever they call home

WesleyLife Values

Quality    Integrity    Dignity    Stewardship    Community

Bringing energy and passion every day. Placing the team before me. Making the healthy choice the right choice.

WesleyLife Memory Support Services

- WesleyLife serves approximately 125 residents in designated memory support households
- Nationally, approximately 70% of nursing home residents have a dementia diagnosis
- Hundreds of additional older adults with dementia are served by us in other community settings
- Growing number of independent living residents show signs of dementia

Background

Why memory support?
- Alzheimer's Association estimates nearly 70,000 Iowans over 65 have Alzheimer's Disease
- 1 in 3 seniors has dementia at time of death
- WesleyLife focuses on services for older adults
- Recognition that we could do better in this area

7/29/2014
History of Memory Support Task Force

- Launched in September 2012
- Original team included cross-functional representation across the organization
- Completed assessments of current memory support services in all communities
- Identified improvement opportunities in 9 areas

From Opportunities to Recommendations

- Determined key metrics and established a dashboard to measure results
- Task force defined objectives for each of the 9 areas of opportunity
- Teams of 3-6 were launched including representation across organization for each improvement area
- Each team identified 3-5 recommendations to address the objectives and improve identified aspects of memory care services
- Recommendations were presented to leadership and implementation plans were developed

Dashboard Example

Actions Taken to Reduce Need for Psychoactive Medications

- More focus on hiring right team members
- Increased activity levels
- Implementation of ABC behavior approach
- Installation of BrainFitness technology
- Training for team members
- Increased involvement of volunteers

Why Reduce Antipsychotic Medications?

- Many of these drugs have side effects of drowsiness and confusion
- Increased falls and reduced ability to perform activities of daily living
- Minimal evidence that antipsychotic medications actually improve targeted symptoms
- CMS initiative to decrease antipsychotics by 15%

Psychoactive Medication Trends at WesleyLife Communities
Barriers to Reducing Psychoactive Meds

- Staff shortages or agency staff
- Lack of dedicated activity professionals at some communities
- Residents coming into memory support households already on anti-psychotics
- Family resistance to medication changes
- Environment changes
- Aggressive behavior frequently results in requests for anti-psychotic medications

Discussion Questions

- What’s the perception of need in the greater community related to dementia services?
- Improving our website and communication – what information would be most helpful for consumers?
- What questions should your patients and their families be asking you when a dementia diagnosis is made?
- Exploring innovative memory support care across the country: Do you have examples that come to mind?
Managing Psychoactive Medications in Dementia Patients

Yogi Shah MD, MPH
RL Bender MD
Des Moines, Iowa
2014

Learning Objectives
- To educate on use of psychoactive medications.
- Non-pharmacological approaches and tools to manage the behaviors frequently experienced by people with dementia.
- By reducing psychoactive medications, we expect to see increased alertness, reduced fall risk, and possibly delays in cognitive decline.

Learning Objectives
- Share current trends of psychoactive medication use for memory support residents
- Discuss tools available to manage behaviors
- Share success stories from communities with low psychoactive medication usage
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Dementia and Delirium
Dr. Yogi Shah

Objectives
- What is Neurocognitive disorder (NCD)
- What is Delirium
- Choose Wisely

DSM 5-2014
- Mild Neurocognitive Disorder
  - Mild Cognitive Impairment (MCI)
- Major Neurocognitive Disorder (NCD)-dementia
  - Alzheimer’s NCD
Functional Status

- Lawton IADL Scale
- Barthel ADL Index

Behavioral and Psychological symptoms in Dementia (BPSD)

- 90% in NH
- 50% in non-NH
  - 20% physically aggressive
<table>
<thead>
<tr>
<th>Psychotic features</th>
<th>Nonpsychotic features</th>
</tr>
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<tbody>
<tr>
<td>delusions and hallucinations</td>
<td>agitation, resistiveness to care, disinhibition, wandering, sleep disturbance, apathy and depression</td>
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**BPSD in Long Term Care**
- Agitation 80%
- Depression 40%
- Aggression 40%
- Psychosis 33%

**Criteria to Diagnose Delirium**
- Disturbance of consciousness
- Change in cognition or perception disturbance
- Rapid onset and tendency to fluctuate
- Evidence that disturbance is caused by consequences of a general medical condition

**Delirium Statistics**
- 6% to 12% LTC
- 15% to 55% hospital
- 25% to 60% post hospitalization

**Delirium/Dementia**
- LOC-fluctuate
- Acute
- Inattention, drowsiness, distractibility
- Reversible
- LOC-alert
- Chronic
- Amnesia, aphasia, agnosia and apraxia
- Irreversible-usually

Culp et al, J of Neuroscience Nursing
Five Things Physicians and Patients Should Question

1. DON’T RECOMMEND PERCUTANEOUS FEEDING TUBES DURING ADVANCED DEMENTIA

2. DON’T USE SLIDING SCALE INSULIN FOR LONG-TERM DIABETES MANAGEMENT

3. DON’T OBTAIN A URINE CULTURE UNLESS THERE ARE CLEAR SIGNS AND SYMPTOMS

4. DON’T PRESCRIBE ANTIPSYCHOTICS FOR BPSD

American Medical Directors Association

http://www.choosingwisely.org/
DON’T ROUTEINLY PRESCRIBE LIPID-LOWERING MEDICATIONS

DON’T RECOMMEND PERCUTANEOUS FEEDING TUBES DURING ADVANCED DEMENTIA

AVOID ANTIPSYCHOTICS TO TREAT SYMPTOMS OF DEMENTIA

AVOID MEDICATIONS TO ACHIEVE A1c < 7.5%

AVOID BENZODIAZEPINES OR OTHER SEDATIVE HYPNOTICS IN OLDER ADULTS
Whenever a patient with dementia develops new symptomatology one must evaluate it very carefully since these patients obviously have more difficulty communicating exactly what they are experiencing. This is particularly true for difficulties in the psychiatric realm.

General approach (cont.)
- The first step is to and physical exam. Most of the time, one must rely on the caregivers to give the history. The physical is very important, since often with these patients their only expression of a physical ailment may be with a change in mental status. Therefore, to assume that the problem behavior is due to a psychiatric complication of their dementia may be erroneous.

Differential Diagnosis for Behavioral Difficulties in the Demented Patient
- A very useful mnemonic is the following:  
  - DEMENTIAS
Mnemonic

- D = Drugs
- E = emotional/psychiatric disease
- M = metabolic derangement
- E = endocrine disease
- N = nutritional problems and degenerative neurologic disease
- T = trauma
- I = ischemia, inflammation, infection
- A = anoxia, arrhythmia, anemia
- S = sensory, social, or spiritual isolation

General Approach {cont.}

- Once you have the h and p, the lab work, and differential diagnosis considered, one can initiate intervention appropriate to the diagnosis. It is important to note that all these diagnoses demand consideration for intervention regarding triggering events, the environment, caregiver stress, as well as pharmacologic and non-pharmacologic potential treatments.

Agitation

- This is often a non-specific umbrella term for many behaviors and symptoms: Anxiety, irritability, restlessness, aggression, screaming, rummaging, sundowning, and catastrophic reactions. It is important to be as specific as possible so that treatment can be most appropriate.

Intervention for Agitation

Get a good initial evaluation: is there a reversible cause?
Non-pharmacologic interventions:
Avoid confrontation
Remove environmental triggers
Create quiet, calm environment
Structure daily routine
Address pain, discomfort
Consider aromatherapy

Pharmacologic Interventions

- Cholinesterase inhibitors
- BuSpar
- SSRIs
- Anticonvulsants (valproic acid, Tegretol)
- Benzodiazepines
- Antipsychotics {Seroquel, Zyprexa, Geodon}

Sundowning

- This is a particular type of agitation in which the patient has symptoms in the late afternoon or early evening.
- The same steps should be taken as outlined previously.
- Additionally, striving to keep the living area well lit, and only gradually decreasing the light before bedtime can be helpful.
- Also, giving some medication 30 to 60 minutes before the anticipated behaviors can be helpful.
- Trazodone, benzodiazepines, and the antipsychotics can be tried.
**Delusions**

- These are false beliefs. They occur very frequently in patients with dementia.
- They are often paranoid and accusatory.
- They may simply result from a misidentification or misinterpretation of the environment.

**Intervention for Delusions**

- Non-pharmacologic:
  - Reassurance
  - Distraction
  - Benign neglect
  - Validation therapy
  - Remove objects that are being misidentified

**Pharmacologic intervention for delusions**

- The drugs of choice are the newer atypical antipsychotics: Seroquel, Zyprexa, Geodon, Abilify, Risperdal.
- Both Risperdal and Zyprexa are supplied as orally disintegrating tablets that may be helpful

**Hallucinations**

- Most commonly in dementia, these are visual. However, other senses can be involved.
- These can often be managed nonpharmacologically: reassurance, distraction, and benign neglect are often enough.
- When the hallucinations are disturbing, the atypical antipsychotics are recommended.

**Resistiveness to Care**

- This is one of the most common and frustrating behavioral difficulty in dementia.
- Non-pharmacologic interventions:
  - Limit goals
  - Use a gentle, slow approach avoiding too many directions at once. Some patients will cooperate for a reward.
  - If these strategies don’t work, generally pre-care administration of a low dose benzodiazepine is recommended.

**Disinhibition**

- This is seen most commonly in patients with frontotemporal dementia, but can certainly be seen in AD and other diagnoses
- Patients say and do things that they would not have done. This is a great source of stress and embarrassment for caregivers.
- A comprehensive strategy is called for.
Non-pharmacologic interventions for disinhibition

- Examine environmental triggers
- Avoid situations in which patients are likely to act out.
- If patients are sexually disinhibited, the caregivers might consider restrictive clothing like a jumpsuit that zips in the back.
- Advise caregivers to carry an “information card” that can help explain what is happening without having to talk about it in front of the patient.

Pharmacologic intervention for disinhibition

- Anticonvulsants
- Beta blockers
- SSRIs
- Sexual disinhibition can be treated with SSRIs, medroxyprogesterone acetate, and Lupron.

Wandering

- Potentially very dangerous
- Provide daytime exercise and outdoor time
- Sleep disturbances should be treated to prevent nighttime wandering.
- Door locks and security systems should be in place.
- Placing a dark tape across the floor of a doorway may help; many patients will not cross the imagined threshold.

Pharmacologic Tx of wandering

- Generally, this has been ineffective
- Dopaminergic therapy in a small group of patients has been studied with some promising results.
- Consider akathisia
- Enroll patient in a wander alert program
- “Safe Return” is a national project that is available [888 572 8566]

Apathy

- This has recently been recognized as one of the BPSDs
- It is different than depression, although it can be a part of depression.
- Caregivers note a lack of interest, decreased activity, and decreased efforts at personal hygiene.
- Caregivers may need to lower expectations
- Provigil and Ritalin are pharmacologic options

Depression

- Two major failings in geriatrics: to miss the diagnosis and then not cure it.
- At least one quarter of patients with dementia have significant depression.
- It’s important to note, that many patients with dementia can tell us how they are doing emotionally. We need to listen. For those patients who cannot describe their emotions, we need to have a high index of suspicion.
Diagnosis of Depression

- Sig: E Caps mnemonic:
- S: Sleep disturbance
- I: Decreased interest in activities
- G: Guilty feelings
- E: Energy decline
- C: Concentration becomes more difficult
- A: Appetite problems
- P: Psychomotor problems
- S: sadness and suicidal ideation

Treatment of Depression

- Non-pharmacologic interventions:
  - Socialization
  - Exercise
  - Sunshine
  - Use of talents for self and others
  - Positive thinking
  - Counseling

Pharmacologic treatment of depression

- SSRIs
- SNRIs
- Tricyclics
- Adjuvant therapy with psychostimulants, Lithium, anxiolytics, and antipsychotic agents.
- MAO inhibitors
- ECT

Sleep Disturbance

- As the demented brain deteriorates, it has more difficulty reacting to the normal circadian clues that support a normal sleep-wake cycle.
- Start with good sleep hygiene: exercise, outdoor activity, restriction of alcohol and caffeine, limiting naps, and addressing pain and incontinence
- Enhance the difference between night and day with good lighting during waking hours, gradually decreasing as bedtime approaches.
- Review meds to make sure they are not a source of interference

Meds for sleep

- Avoid benzodiazepines except for Restoril. This agent does not seem to affect sleep architecture like the others.
- Sonata
- Ambien
- Low dose atypical antipsychotics like Seroquel
- Trazodone
- melatonin

CASE 1 (1 of 4)

- A 76-year-old woman is admitted to the hospital for elective right hip replacement.
- History includes hypertension and type 2 diabetes mellitus. Medications are enalapril and metformin.
- She complains of mild forgetfulness, often misplacing her keys or where she left the mail, but otherwise has been healthy.
- Until 3 months ago, she was swimming 3 miles a week. Since then, her activities have been limited by right hip pain.
CASE 1 (2 of 4)

• On physical examination, vital signs are stable. BMI is 22 kg/m². There is decreased range of motion of the right hip and pain.

• The patient’s score on the Mini–Mental State Examination is 28 of 30, with 1 point lost on serial 7s and 1 point lost on recall of 3 words at 5 minutes.

CASE 1 (3 of 4)

Based on current guidelines, which of the following is appropriate for preventing delirium in this patient?

A. Delay ambulation by ≥ 1 additional days after surgery to encourage early healing.
B. Prescribe a rapid-onset benzodiazepine to promote sleep hygiene.
C. Avoid multiple moves between rooms during the postoperative period.
D. Start a low-dose cholinesterase inhibitor.
E. Avoid rigorous hydration during the perioperative period to prevent pulmonary edema.

CASE 2 (1 of 4)

• An 89-year-old woman is admitted to the hospital with a urinary tract infection and change in mental status.

• History includes type 2 diabetes mellitus, depression, and anxiety.

• She moved in with her daughter 8 months ago because of worsening confusion. Her family notes that her short-term memory is impaired and that she has vivid visual hallucinations of children in the house. They are unaware of any specific diagnosis regarding her cognition.

CASE 2 (2 of 4)

• On examination, temperature is 38°C (100.5°F), BP is 132/78 mmHg, heart rate is 86 beats per minute, and oxygen saturation is 96% on room air.

• Examination is unremarkable except that the patient is unable to recite the months of the year or days of the week forward.

• Although nonpharmacologic treatment is initiated for delirium, the patient becomes severely agitated overnight.

CASE 2 (3 of 4)

Which of the following is the most appropriate treatment for this patient’s agitation?

A. Haloperidol
B. Rivastigmine
C. Quetiapine
D. Trazodone
E. Physical restraints

CASE 3 (1 of 3)

• A 78-year-old man is admitted to the hospital for elective left total-knee arthroplasty. History includes hypercholesterolemia, obesity, and osteoarthritis.

• He tolerates the surgery without difficulty, but 3 days later he appears somnolent. He falls asleep during breakfast and, even though the nurse converses with him, dozes off during his dressing change. When he is awake, he stares out his window.

• Vital signs and laboratory findings are stable. Neurologic examination is otherwise normal. His surgical wound shows no evidence of infection.
CASE 3 (2 of 3)

Which of the following is most likely to help establish the diagnosis?

A. Orientation to person, place, and time
B. Orientation to person, place, and time and ability to draw a clock
C. Ability to recite the months of the year or days of the week forward
D. Score on Geriatric Depression Scale
E. Score on visual analogue pain scale
To transform the health & well-being for those with dementia and Alzheimer’s disease...

- **Paradigm shift.**
  - What needs to change in our thinking and actions?
  - What assumptions do we need to challenge?

- **Collaboration.**
  - How can we rally around a shared vision?

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### If you live to 100 years-old, what kind of 100 year-old do you want to be?

- 6x world marathon record holder
- Started running at 80
- Now 102
- Spokesperson for Adidas

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### The truth is, individuals...

<table>
<thead>
<tr>
<th>Do not have to...</th>
<th>To be...</th>
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<tbody>
<tr>
<td>Look a certain way</td>
<td>Engaged in life</td>
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<tr>
<td>Participate in extreme sports</td>
<td>Resilient</td>
</tr>
<tr>
<td>Or be free of functional or cognitive challenges</td>
<td>Experience well-being</td>
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### Transformation in Action

1. Medical Model → Well-Being Model
2. Limitations → Potential
3. Care Plan → Well-Being Plan
4. Life Span → Health Span
5. Provider Directed → Person Directed
6. Healthcare → Hospitality
Why is “Well-Being” a Strategy for WesleyLife?

- Residents now and even more so, in the future, will look for a place to spend their later years that promises them health and well-being.
- Employees seek a work environment in which they feel valued, supported and cared about through health & safety programs, policies, benefits and positive working relationships.
- WesleyLife can contribute to improving the well-being of the broader community through home & community-based programs and services.

Well-Being: A Broader Scope

5 universal, interconnected elements:
- Career/Purpose well-being
- Social well-being
- Financial well-being
- Physical well-being
- Community well-being

Focusing on the Possibilities

<table>
<thead>
<tr>
<th>Culture &amp; Environment</th>
<th>Training &amp; Education</th>
<th>Innovative Programming</th>
</tr>
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<tbody>
<tr>
<td>Language for Living</td>
<td>Staff</td>
<td>National Memory Screening Day</td>
</tr>
<tr>
<td>Creating spaces with sites, sounds, smells that promote health &amp; healing</td>
<td>Physician</td>
<td>Brain health week</td>
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<td></td>
<td>Families &amp; Caregivers</td>
<td>Grants – Dakim</td>
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<td>Partnerships – Alzheimer’s Association, DMU, Abe’s Garden</td>
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</table>

What’s your view?

So What? Group Discussion

To transform the health & well-being for those with dementia and Alzheimer’s disease...

- Paradigm shift.  
  - What needs to change in our thinking and actions?
  - What assumptions do we need to challenge?

- Collaboration.  
  - How can we rally around a shared vision?
Reverse It

http://www.youtube.com/watch?v=vevavSuhxGRQ