Long-Term Care: Dementia-related Psychosis Call

Moderated by: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this Medicare Learning Network call on Long Term Care Dementia-Related Psychosis.

During this call, learn about the appropriate assessment after a diagnosis and approaches to care for dementia-related psychosis in the long term care setting. Hear about customized care strategies for nursing home residents. A Q&A session follows the presentation.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL – go.cms.gov/mln-events. Again, that URL is go.cms.gov/mln-events.

This call is open to everyone. If you are a member of the press, you are welcome to listen, but please don't ask questions during the Q&A session. Send your inquiries to press@cms.hhs.gov. At this time, I would like to turn the call over to Michele Laughman from the Division of Nursing Homes to introduce our speakers.

Presentation

Michele Laughman: Good afternoon, everyone, and thank you for participating in today's Medicare Learning Network call. The speakers for today's session are from The Gerontological Society of America or GSA Workgroup on Dementia-Related Psychosis. The GSA is an interdisciplinary organization devoted to research, education, and practice in the field of aging.

The GSA established its Clinical Workgroup on Dementia-Related Psychosis in July of 2020 to raise awareness about new clinical evidence and best practices that can help improve the care and support received by individuals with dementia-related psychosis and their family.

Going in the order of their presentation, the speakers are as follows – Dr. George T. Grossberg, who is a Samuel W. Fordyce professor and Director of Geriatric Psychiatry in the Department of Psychiatry and Behavioral Neuroscience at St. Louis University School of Medicine.

Dr. Alexis Eastman is a Medical Director in the Division of Geriatrics at UW Hospitals and Clinics and an Associate Professor at the University of Wisconsin School of Medicine and Public Health.

Ms. Susan Scanland is the CEO and founder of Dementia Connection Clarks Summit. And Dr. Chad Worz is the Executive Director and Chief Operating Officer of the American Society of Consultant Pharmacists. I will now turn it over to Dr. Grossberg.

Dr. George Grossberg: Thank you very much. And I want to thank Michele Laughman for making this happen and giving us this opportunity for this educational program, and also to Judit Illes from the GSA, The Gerontologic Society of America, for really bringing all of us – all of our speakers together to talk about this important topic.

On the first slide is basically something we have already covered. But, on our second slide are the acronyms which – you may or may not be familiar with some of these in this presentation. Obviously, we're all familiar with activities of daily living. But BPSD refers to Behavioral and Psychological Symptoms of Dementia. CMS – we're very familiar with, Electronic Medical Record. Gradual Dose Reduction – we're also becoming very familiar with. It's very important. The GSA, The Gerontologic Society. We'll talk about the IPA's contribution to defining psychosis against the background of dementia. And, then, primary care providers.

So, our program really looks at residents with dementia-related psychosis. We'll be focusing on strategies for evaluation and care. Slide four. You've already heard about our presenters, but here are the more formal kind of qualifications of everyone.

And, very importantly, on slide five are disclosures. Some of us have disclosures with various companies. I, myself, work with a number of pharmaceutical companies, both small and large, mostly to develop new treatments for Alzheimer's disease as well as for the symptoms of dementia including the one we'll talk about today.

So, slide 6 looks at our agenda. We'll be defining what we mean by dementia-related psychosis and how we kind of try to arrive at that diagnosis. You will hear I think a very interesting and informative case study on making an accurate diagnosis.

We'll focus more specifically on dementia-related psychosis in the long-term care environment specifically looking at care strategies. We're going to look at tips for documenting and ongoing monitoring of these symptoms. And then, we're going to be following up at the end with, a hopefully, a lively question-and-answer session. So, please don't hesitate to ask questions from all of us.

Slide 7 looks at our learning objectives. We're going to try to kind of understand the definition of dementia-related psychosis, talk a bit about hallucinations and delusions, to recognize the signs and symptoms in long-term care residents and how to intervene in a timely manner.

We'll know when to communicate with family and residents and what to communicate during care management. We'll hopefully, have a better understanding of non-pharmacologic approaches in this arena as well as what do we know, what evidence do we have relative to pharmacologic interventions and then, lastly, to be able to really apply best practices in documentation and ongoing monitoring of our residents in long-term care.

So, this is myself. And let's talk about initially the symptoms of dementia-related psychosis. So, when I think about dementia-related psychosis, I'm thinking about an individual, maybe a patient in long-term care – in the spectrum of long-term care that's having either delusions, which are firm, false beliefs that kind of don't jive with our sense of reality and/or hallucinations.

And hallucinations usually involve the person seeing things. So, in dementia, visual hallucinations, seeing things that you and I don't see are much more common than auditory. But it could also be hearing things, maybe hearing things inside their head that you and I don't hear.

Some evidences of psychosis could involve things like incoherent or kind of nonsensical speech or maybe being internally preoccupied. So, you are talking to the resident and they're talking to somebody else because they are hearing voices inside their head. Or there may be kind of lack of insight when the individual kind of interacts with visual hallucination.

So, for example, you might see a dementia patient kind of picking at things. Maybe they're bugs, whatever, that you and I don't see. Or they may be talking about seeing strange children outside their window or maybe seeing a frightening creature outside the window, which is what I had with a patient very recently.

Now, slide 10 looks at the symptoms of dementia-related psychosis and how common they are and how they kind of stack up. One of the things that we know is that the symptoms of dementia-related psychosis can be, in fact, quite frequent. In fact, most older adults with either hallucinations and/or delusions against the background of dementia will experience these symptoms almost daily – two to six times per week.

They can be episodic, but they can also be quite persistent. So, about half, relative to hallucinations, the persistence is greater than three months and, relative to delusions, over 80 percent of a persistence that's greater than three months. A common delusion, for example, might be that the medication that the nurses are giving me is poison or the food is poisoned, or someone is trying to hurt me – paranoid kinds of delusions. These are also very, very common.

And what we also know from the literature and from the research is that if untreated, these symptoms can definitely get worse over time. So, there is every incentive for us to intervene and intervene early before things get worse.

The next graphic looks at kind of the whole range of what we said were BPSD, the Behavioral and Psychological Symptoms of Dementia, and how they can be impacted by environmental factors, interpersonal issues, having a roommate maybe that's themselves having some of these kinds of symptoms.

But, if you look at the dementia spectrum of behaviors, psychosis is at the top. It's not necessarily the most common but one of the most common. And it may be interrelated with agitation. It may even trigger overtly aggressive behaviors. It may coexist with other psychiatric conditions. One of the things that I found in my Alzheimer's patients, for example – very high prevalence of coexisting depression.

And, of course, we want to keep in mind is the potential trigger underlying medical problems. Could the individual be having pain, for example? Could there be some medications on board – we'll talk about delirium in a little bit – that are causing acute confusion or delirium, which can itself be accompanied by psychotic features?

If you look at the small print – and we're looking at slide 11 – under the asterisk on the bottom, you'll also see that there are other common kind of behavioral and psychological symptoms in the dementias including apathy, lack of motivation, indifference, psychosis, depression.

Sleep disturbances are very, very common. And we think that sleep disturbances and as well as sundowning are really due to circadian rhythm alterations that we see with the dementias and in particular with conditions like Alzheimer's disease. And we're learning a lot more about these. And then, of course, agitation and aggressivity can be quite troublesome and not rare.

Our next graphic, 12, looks at the prevalence of dementia-related psychosis in the what I call the five most common dementias not necessarily in order of prevalence. But what we find is that there are almost 2.5 million older adults in the United States with dementia-related psychosis.

And it occurs quite frequently in all of the major dementias, maybe more than half of patients during the course of their disease depending on the type of dementia they have. And, as we see, we see the numbers affected by the various dementias and the percentages that we'll have over the course of that dementia either hallucinations and/or delusions.

We find that Lewy Body Dementia, which affects nearly half a million older Americans, Parkinson's Dementia – over 300,000 – have the highest prevalence of psychosis, both hallucinations as well as delusions. But, even the Alzheimer's patients, who are about 5.8 million Americans – we see, in fact, delusions are close to 40 percent in some studies and hallucinations are also not rare.

Less common in Vascular Dementia. And then, least common – the psychotic symptoms would be least common in what we call Frontotemporal Dementia, which used to be called Pick's disease, which is not so common. It's the least common of the top five progressive brain diseases that cause dementia.

Now, let's talk about kind of a new clinical definition. This is very recently published. It's a revision of a previous definition. But this definition coming from the International Psychogeriatric Association workgroup is really kind of an update of an older definition. It is now being used both clinically as well as for research and has also now been adopted by agencies including the FDA as a way to define dementia-related psychosis for clinical trials, for research activity.

And here is what's required. So, first, we have the characteristic symptoms. So, we need the presence of one or more of the following, which we talked about earlier – visual or auditory hallucinations and/or delusions, the firm false beliefs that we know aren't real. We need to have a primary diagnosis of dementia.

And, very importantly, if we're thinking about psychosis that's coming out of the dementia rather than due to something else, we want to make sure that the psychotic symptoms come after, that there is evidence from the patient history that the symptoms have not been present prior to the diagnosis of dementia.

So, an example might be an individual, let's say, with a psychotic illness or long history of schizophrenia. Now, they are not immune from becoming demented or developing a dementia later like Alzheimer's disease. So, if that patient shows psychotic symptoms but we had psychosis preceding the dementia, that is not part of what we're talking about today.

Duration and severity have also been defined by the IPA, that these symptoms have been present at least intermittently for a month or longer. And then, I think something that, to me, is the most important is that they're

severe enough to really disrupt functioning, disrupt functioning of either the patient and/or the caregivers – the nursing staff, for example – or other residents in the environment. So, we want these to be impactful.

We want to rule out, as I mentioned earlier, things like schizophrenia or other psychotic disorders. This is, again, part of the criteria that we want to keep in mind. A really big rule out, something that we want to be thinking about first in every patient who shows psychotic symptoms against the background of dementia, is could they have a delirium. Could they have an acute confusional state?

We want to keep in mind that any and all causes of delirium can be accompanied by psychotic features. I think what all of you know and all of us know is things like a urinary tract infection or infections in general or anticholinergics or bad drugs, narcotic analgesics and so on – they can cause a delirium which, then can be accompanied by psychotic features.

And, of course, we want to rule out medication, substances. With cannabis now being available legally all over the United States, that may be a cause – underlying medical problems. And, of course, we can have associated features like agitation, overly aggressive behavior, negative symptoms or even depression as part of this spectrum of symptoms that we see.

So, what about outcomes for residents with dementia-related psychosis? And there is really good literature now to back each of these up. What we know is that the resident with dementia that has dementia-related psychosis – that this, in fact, is a risk factor for winding up as a resident in long-term care. And there is also increased mortality.

We also know that having psychotic symptoms against the background of dementia such as hallucinations and delusions really causes a more rapid decline cognitively as well as functionally relative to activities of daily living. And, of course, dementia-related psychosis is highly distressing for both the persons with dementia as well as their care partners.

And it negatively impacts both their quality of life as well as their personal relationships. And we know as we interview professional caregivers like in long-term care that it's these kinds of symptoms – dementia-related-type symptoms – that really get them worn out. It's a high cause of stress and emotional exhaustion among professional caregivers.

So, at this point, I'm going to turn the baton over to Dr. Alexis Eastman for a very interesting, wonderful case study on making an accurate diagnosis. Alexis?

Case Study on Making an Accurate Diagnosis

Dr. Alexis Eastman: Great. Thank you, Dr. Grossberg. So, for those of you following along. I'm on slide 16 with my little head shot from work nicely presented there. And using a (inaudible) of IPA criteria and translating them into a workable case, something that I've certainly seen in my practice represented and I'm sure you have as well.

So, if we look at the next slide 17, we've got a case study on Mrs. Jones, a resident experiencing psychosis. So, Mrs. Jones is an 87-year-old female who has a history of hypertension and hypothyroidism who has been

diagnosed with late-onset major neurocognitive disorder, colloquially known as dementia, probably Alzheimer's disease.

She lives at Sunnycreek Skilled Nursing Facility and was previously cared for at home by her husband, who is her activated health care power of attorney. So, at baseline at Sunnycreek, she is very sociable. She interacts with staff. And like many facilities, they have ice cream socials, and she regularly attends them to socialize with other residents and generally pleasant and interactive.

However, in the past six weeks, she repeatedly claimed to see a strange man in her room, usually in the evenings, rummaging through her belongings and stealing things. Now, the staff has confirmed that there was no one entering or exiting the room when Mrs. Jones claims to see the man, and the family confirms she has no history of past trauma that might trigger these episodes as a type of post-traumatic stress or a trauma response.

So, because of these visits, Mrs. Jones is now in a continually frightened state and she cannot be reassured. In fact, last week, she claimed to see the same man outside the dining room window at Sunnycreek and she threw a plate of food at him. The staff has called her husband and arranged for her primary care provider, Dr. Price, to come do an onsite visit at the facility to see Mrs. Jones.

So, already, we're starting to move ourselves down that set of IPA criteria that Dr. Grossberg clearly highlighted. We've got a set of symptoms of visual and possibly auditory hallucinations in the setting of a known dementia. While we have not established that the dementia predated the hallucinations, that's the implication. And they have been going on for more than a month and are severe enough to disrupt function and certainly her quality of life.

So, then, we get to slide 18. And that's when Dr. Price goes to see Mrs. Jones at Sunnycreek. And during the visit, Dr. Price, who has known Mrs. Jones fairly well, sees that Mrs. Jones is anxious. She is avoiding eye contact. She is fidgeting, physically restless, and she is talking to someone who is in the corner or the room, who's not there.

And, so, Dr. Price says this is – this is something that needs careful review. So, he reviews Sunnycreek's chart and notes that the vital signs and weights over the past few months appear to be just fine. Unfortunately, there are some limited notes about Mrs. Jones' hallucinations and the non-pharmacologic approaches tried so far by the staff to help her with these.

Dr. Price then reviews the medications, keeping in mind that dementia-related psychosis can be from other diseases or substances – in this case, medication – and notes that she is on the appropriate dose of an angiotensin-converting enzyme inhibitor, a thyroid medication and a cholinesterase inhibitor. And, then, she has had no recent use of her as-needed medications such as sedatives or antihistamine.

And looking for other possible causes, Dr. Price considers the possible environmental and physical triggers such as lights or shadows, which in older patients with changing vision could look like people or other creatures; external noise, which could sound like someone coming into the room; or unmet needs that could trigger a delirium-like presentation such as hunger or pain or a need to toilet.

So, as you can see here, Dr. Price has sort of a systematic approach, first looking at the patient and seeing how is she different from her baseline and, then, reviewing what has gone on over the past couple of weeks that may be medical or behavioral in nature to identify what has really changed from the baseline, looking at the medications that she is on to make sure that are appropriate, seeing how often as-needed medications might be used, considering all the other environmental or physical triggers that might be contributing.

And then, moving on to slide 19, Dr. Price reviews the medical history, noting the diagnosis of dementia with probable Alzheimer's type and hypothyroidism, and interviewing the spouse to really establish which happened first – the hallucinations or the dementia. And then, her husband reports no hallucinations in the past, sort of firmly establishing that the dementia was the first diagnosis, and these hallucinations are new.

And then, it's not sufficient just to review the medications the patient is on to see if they're appropriate, it's also – and correctly dosed – it's also really important to look at the medications to see if they carry any additional risks related to the patient because of their age or their dementia.

And, so, utilizing excellent nursing home pharmacists, Dr. Price can review the current medications to identify which ones might have side effects and are potentially inappropriate in individuals with dementia and, often, if they're listed in the American Geriatrics Society Beers Criteria list.

And these are things like anticholinergics, benzodiazepines, sedative hypnotics and antipsychotics. And then, getting back to focusing on the patient, Dr. Price needs to conduct a good physical exam and identify any underlying medical conditions that could cause delirium that would mimic dementia-related psychosis – things like infections as well as pain.

So, having done that, Dr. Price, then, will take that work up a little bit further to rule out disease that either are out of control or undiagnosed that may be contributing and, so, ordering labs like a complete metabolic panel to look for renal or liver disease, obtaining complete blood count to look for occult infection or anemia, obtaining a thyroid stimulating hormone test to make sure that the thyroid disease Mrs. Jones does have is well controlled and getting a urinalysis to look for infection.

And given all of these were normal, fortunately, Dr. Price concludes that Mrs. Jones' current medications are safe after discussing with the pharmacist and that there's no evidence of delirium. And, so, having put all of that together, Dr. Price is then able to differentiate Mrs. Jones' symptoms from other clinical syndromes that could present with hallucinations and delusions such as delirium or schizophrenia or psychotic depression.

And this really looks at the careful evaluation of the timing of symptoms, at the course of them, the prior psychiatric history, the prior inciting events, the other signs and symptoms, as we have sort of discussed earlier in these slides. So, putting all of that together, Dr. Price determines that Mrs. Jones' hallucinations and psychoses are due to her dementia.

And that's really kind of the way you work through the logical order of the IPA criteria in sort of a best practice format to identify "Is this patient suffering from dementia-related psychosis, or is there another underlying condition that needs to be addressed prior to intervening on the psychosis?" So, with that, I am turning it over to Susan Scanland, who is going to give us an in-depth discussion about how to address and manage this in the long term care setting.

Evidence-based Care Strategies

Susan Scanland: Thank you, Dr. Eastman. We're now starting on slide 22. And I'm going to focus on use of non-pharmacologic strategic. So, what Dr. Price then does is wanting to start with non-pharmacologic measures before going to medication for behavioral and psychological symptoms of dementia. She talks to the staff about adding non-pharm approaches. And this is individualized because Mrs. Jones is absolutely having anxiety caused by the hallucinations.

The staff then does create a playlist with Mrs. Jones' favorite Frank Sinatra and Dean Martin songs. The unit nurse manager does encourage the staff to use validation therapy to communicate with Mrs. Jones when her hallucinations are present. The CNAs begin lavender aromatherapy early each evening and offer hand massages at bedtime.

So, I'm going a little bit about systematic reviews of non-pharmacologic interventions. There are two studies that are listed here which I highly recommend you take a look at. This study showed that for BPSD, music therapy and communication techniques based on home-based behavioral management, caregiver-based interventions and staff training in communication skills are really effective for severe agitation. So, like I said, we're hoping that, with Mrs. Jones, these will impact especially the hallucinations that she is having.

There are many other non-pharmacologic techniques that have been really helpful even though there is not a lot of strong evidence in the research itself. And this includes validation therapy, reminiscence, aromatherapy especially with lavender and lemon oil, massage. For massage, it seems to be really effective to use hand massage, shoulder and neck massage. And surprisingly, shiatsu massage also comes out looking strong in the literature.

Music playlists and validation therapy do improve Mrs. Jones – her daytime behaviors moderately over the next week, and the staff is happy with that. But what happens in the evening, as you'll often see in your residents with sundowning, despite the aromatherapy and the bedtime hand massages, her nighttime psychosis worsens, and she is now seeing these hallucinations getting more severe.

She is now seeing a number of people in her room who are now carrying knives. She has a delusion that her mother is still alive, and she is crying out for her mom for help. She is also having delusions that staff are strangers that are trying to poison her with her evening medication – paranoid delusions.

So, one evening – one morning, actually, at 3:00 a.m., the staff find Mrs. Jones screaming at the top of her lungs that she needs to escape from the knife people. Despite attempts by the staff to calm her with these non-pharmacologic approaches, she remains distressed. So, the next day, the staff call Dr. Price to inform her that Mrs. Jones' hallucinations and delusions are worsening and that the non-pharmacologic strategies have not significantly affected her condition and quality of life.

So, now, moving to slide 24, Dr. Price recommends starting Mrs. Jones on an atypical antipsychotic. Dr. Price educates the staff about the need to continue to monitor and provide the medication since we don't see results immediately. The impact on the hallucinations and delusions usually takes several days.

The hallucinations appear to decrease, and Mrs. Jones seems much less distressed. Now that she's on a medication, she is much more responsive to music calming her. So, as the medication kicks in, she is doing much better with the non-pharmacologic interventions.

She is now looking forward to her hand massages at bedtime and then relaxes until she falls asleep with the lavender aromatherapy. So, the staff are now documenting in their log that after a week, episodes of Mrs. Jones seeing shadowy, frightening figures has decreased by 50 percent.

So, Dr. Price wants to speak with Mr. Jones because he is very concerned about his wife's treatment. So, he talks to Mr. Jones about the risk-benefit ratio of continuing Mrs. Jones on the atypical antipsychotic. Dr. Price reviews the black box warning for current atypical antipsychotics, which includes the risk of increased – increased risk of mortality.

So, Mrs. Jones is treated for about five months. And after that, the staff – they're observing, they're documenting – Mrs. Jones is ceasing to have delusions and hallucinations. So, given this and concerns about side effects, Dr. Price begins a GDR or a Gradual Dose Reduction of the atypical antipsychotic.

Dr. Price informs the nursing staff Mrs. Jones' care plan, and the staff is going to continue to monitor for potential reoccurrences of hallucinations and delusions and will document these in the EMR. So, with that, I'm going to turn it over to Dr. Chad Worz, and he is going to talk about documentation and ongoing monitoring.

Tips for Documentation and Ongoing Monitoring

Dr. Chad Worz: Great. Thank you, Susan. So, one of the hallmarks I think all of the speakers – Dr. Grossberg, Dr. Eastman and Susan – have spoken to is the need for effective documentation. There is quite a bit of detail in our patient case. There is quite a bit of procedural effort and effort in making the appropriate diagnosis for patients. And the hallmark of that is to provide good documentation in the medical record to support the activities that we're doing to care for these individuals.

So, when you look at slide 27, documentation of provision and effectiveness of care, documentation underpins the treatment rationale for residents in skilled nursing facilities as well as in other environments. And we've all heard this in the long term care setting, but what is not documented is not done.

So, if we think back to what Dr. Grossberg was talking about in establishing the fact that the person was having potentially harmful psychotic symptoms, those are episodes that should be documented and followed as we go through the process of identification of diagnosis as well as when we start to employ non-pharmacologic and pharmacologic interventions.

So, documentation is important. Susan spoke to the fact that some of our earlier interventions might be non-pharmacologic in nature. And while they don't have ample evidence in terms of having a blockbuster intervention that tends to work in everybody, there is good evidence that person-centered non-pharmacologic interventions are helpful.

And I think Susan did a great job of explaining the lavender therapy, the hand massages and the things that we do to try to alleviate some of the behaviors that patients are having. Those are, again, things that really require good documentation to appropriately measure impact that they're having on the care of the resident.

So, the nature of BPSD and the mixed evidence about the safety of non-pharmacologic and the efficacy of non-pharmacologic interventions also applies to the use of psychoactive medications.

So again, documentation becomes the barometer by which we measure the effectiveness of something that we're trying to provide in terms of therapy – so, carefully tracking of changes in behavior, being specific about those behavioral episodes, what was the patient doing – in Mrs. Jones' case, the paranoid delusions about the people with knives, the episodes of seeing – or hallucination of a man standing in the room or outside of the window.

Those are things that we can objectively measure week after week, month after month to identify when something changes that. So, if she had 50 episodes in the month of February but only 23 episodes in the month of March, we could assign that to a particular intervention, a non-pharmacologic or potentially pharmacologic intervention.

We also recognize that these medications, when they're employed, also require proper tracking of behaviors. And we do worry about the use of those medications in older adults because the science is not clear always on what dose to use and what dose is effective. So, if we think about an older individual and the changes of their body chemistry over time, the dose that may have worked for them when they were 60 may not be the dose that they need when they're 80 and there may be reasons to back off the level of dose that's being used.

So, we have systems like gradual dose reduction that we employ to try to get to that right medium of the appropriate dose that's providing the most benefit but also is relieving the individual of any potential harm. So, we document those effectively in the medical record to track what we're doing from the perspective of treatment.

So, the priority, if we go to the next slide, is to have a plan and to make sure that those interventions are all added to the resident's individualized care plan. What are we monitoring? Who is responsible for documenting it? Where is it in the chart so that the other disciplines can reference it when they are looking at changes to whether – again, it's a non-pharmacologic approach or a change in dose or approach to a pharmacologic approach.

And those multi disciplines are important when it comes to behavior management because all of us play a different role in the long term care setting. Dr. Eastman referenced the consultant pharmacist who comes in on a periodic basis to review medications.

Well, it's really those nursing assistants and those nurses that are with patients every day that become the best answers to what's going on with the behavior management. And if they are documenting and documenting specific behaviors, it really informs the nurse practitioners, the physicians, and the pharmacists about what's going on with the ongoing treatment plan.

The other thing to consider is making sure we set expectation with resident families. There are numerous examples of families that have tried to manage their loved one in the home setting, and maybe some of that management involved the use of antipsychotic medications and they became reliant on those medications as they enter the nursing facility.

But, once in the nursing facility, the care and the approach to care changed and it may alleviate the need of those psychoactive medications or antipsychotics. And you may get resistance from family thinking that that was what got them through taking care of the individual, so they need that medication. So, being able to communicate expectations with families is important.

And it also works in the reverse where we do find a therapy, a non-pharmacologic therapy or a pharmacologic therapy, that is effective and we were able to apply it in the nursing home setting, it didn't exist when they were living at home, and they have concerns about that – using a particular medication in their loved one. So, that communication is two-way and has to be central to the care plan for the individual.

If you go to slide 29, looking at some tips for documentation, again, documentation is critical to measuring the impact of interventions, whether they're non-pharm or pharm; current care environment; and medication is free of triggers that contribute to symptoms.

As Dr. Eastman went through the case, you heard her speak to the fact that we're looking at – these hallucinations are occurring at night. Is it a visual issue– are they having problems seeing? If that's not it, is it in their medication regimen? Are they on a medication that has some side effects that might mimic hallucinations and delusions that might be causing a problem?

So, all of those factors we have to appropriately document – that, yes, we looked into this. They're not there. We're moving on to the next level of intervention to try to care for this individual. Explaining the rationale around the approaches – why are we picking this particular non-pharmacologic approach? It's going to address the anxiety that the person is having because they see people in their room. Maybe that's the lavender is working to that. Maybe the hand massages work for that.

If we move to a pharmacologic intervention, being able to track the number of episodes the individual is having – again, if it goes from 12 episodes in one month to six episodes in another month, that's progress that may be related to the intervention. So, the documentation of that is important.

Being very objective about those benefits, the progression, the frequency; being objective about the adverse event risk, not forgetting that if we do move to psychoactive medications or antipsychotic medications there are risks of side effects. And are we watching for those and also documenting those so that we appropriately assess the risk-benefit of the intervention that we're delivering?

If you go to slide 30, again, more tips. Recognizing and understanding the signs and symptoms of psychosis that are documented not only in the medical record but also in the minimum data set. It's that database of information that defines care at the nursing facility for the survey teams that come out to the facility.

And that's where they start when they're evaluating the kinds of things that we're doing at the facility level – so, making sure we understand how things move from documentation in the medical record to the MDS so that it's properly informed.

Being able to document those changes over time – all of these interventions, especially the psychoactive medications, can take four to six weeks to manifest changes. It takes that long to maybe develop a side effect. it takes that long to develop the full impact of any efficacious benefit that we're getting with drugs – so, making sure that we're following that time continuum and apply appropriate objective measures to drugs over time.

Again, talking about communicating with family, it's not a one-time thing. It's an ongoing thing. How are things going? What's the impact that these interventions have made? And then, continuing evaluating and documenting the safety and efficacy of the approaches that we're using, both non-pharm and with pharmacologic agents.

Sometimes we are using multiple psychoactive medications to care for individuals – they have depression, they have anxiety, they have psychotic symptoms that may result in two or three medications being used. When we go to approach a gradual dose reduction, we have to consider that.

It's very difficult if we were to gradually dose reduce three drugs at the same time to determine which one had a positive or negative impact on the care of that individual – so, recognizing that in some cases, we may choose the agent that we feel like is the most risky, do a gradual dose reduction on that agent while leaving the other two in a secondary priority and leaving them at their dose until it's time to make a further reduction and then maybe targeting those medications.

Always using evidence-based medications – sometimes that is evident by FDA-approved indications for certain conditions and symptoms. Sometimes there is evidence of a literature that supports the use of medications but always relying on a body of evidence to support why we're using a particular medication.

When GDRs are contraindicated, when we choose not to do a GDR, again, documentation becomes critically important to being able to substantiate why we're not going to lower a drug. It may be that somebody has a very chronic progressive disease.

It may be that, over time, we've tried GDRs in the past, they've failed, and we're worried about the rebound effect of lowering that medication risk. We've seen it before, so we might not feel comfortable doing a dose reduction. And we can document that and supplement that with what we're seeing with behaviors in the chart if we're tracking them to support the decisions we make when it comes to GDRs.

We always consider risk. Just because it's time for a GDR doesn't always mean that it's safe for the patient. So, being able to document and show the evidence to support whether or not we do go through with the GDR or not go through with the GDR is critically important.

And then, obviously, if we do GDRs and we do see decreases in function or a rebound effect of the symptoms that we were trying to alleviate, then we would document a failed GDR and we would use that in subsequent efforts to make GDR attempts. And, again, it doesn't mean that we wouldn't do a GDR just because we failed once.

But we want to document a good rationale of why we're going to wait and do it later or wait and not do it later based on the documentation that's in the chart. So, I'll turn it over now to Leah, who will give us some more instructions and enter the question-and-answer session.

Question & Answer Session

Leah Nguyen: Thank you, Chad. We will now take your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many questions as possible, each caller is limited to one question.

To allow more participants the opportunity to ask questions, please send questions specific to your organization to the resource mailbox at the end of the presentation so our staff can do more research. Preference will be given to general questions applicable to a larger audience, and we will be mindful of the time spent on each question. All right, Blair. We are ready for our first caller.

Operator: To ask a question, press "star" followed by the number "1" on your touch-tone phone. To remove yourself from the queue, press the "pound" key. Remember to pick up your handset before asking your question to ensure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you are asking your question, so anything you say, or any background noise, will be heard in the conference. If you have more than one question, press "star," 1" to get back in the queue, and we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

The first question will come from the line of Linda Brummett.

Linda Brummett: Hi. I'm Linda Brummett. I work in a senior living building with independent, assisted living and memory care. My question is can you define delusions versus delirium for me, please?

Dr. George Grossberg: This is George Grossberg. Maybe I can address that. So, I believe the question was defining delusions versus delirium.

Linda Brummett: Yes, sir.

Dr. George Grossberg: Okay. So, delirium refers to kind of an acute confusional episode usually in an older adult with or without dementia. And it can be due to many, many different causes, things like bad medications like on the Beers list like the anticholinergics, the benzodiazepines.

It could be due to infections. So, one of the first places we think about – could there be a urinary tract infection or some other kind of infection? It can be due to multiple underlying medical causes. And, less commonly, it can even be due to environmental insults where delusions are psychotic symptoms.

So, not everyone that is delirious is going to have psychosis. But that can be one of the causes of psychotic symptoms. And by a delusion, what we – what we're talking about is someone having a kind of firm, false belief that doesn't kind of concur or agree with our sense of what's real.

So, for example, I had a patient last week who was an older woman in her 80s, came with her husband. She has Alzheimer's disease. And he became very, very distraught when she told me that there was really nothing wrong with her. The problem was really with that guy – she pointed to her husband – because she said, "He thinks he is my husband, but he is actually an impostor." So, that is a delusion, a firm false belief.

A very common one, even more common than that, would be paranoid delusions, accusatory delusions where – we mentioned the patient that we talked about maybe is fearful that someone is trying to poison them or to harm them. So, they are very different entities.

But delusions – one of the causes of delusions or of psychotic symptoms in general can be an underlying delirium. Once we find the cause, address the cause and treat it, then, if the psychotic symptoms were coming from the delirium, they should resolve.

Linda Brummett: Perfect, Perfect.

Dr. George Grossberg: It's a great question.

Linda Brummett: Thank you, sir.

Operator: Our next question will come from the line of Sharon Clackum.

Sharon Clackum: Hi. My name is Sharon Clackum, and I'm a consultant pharmacist. I have a couple of patients that are – that have Parkinson's psychosis and have been started on Nuplazid and is now time – it's time for a gradual dose reduction. And I'm torn because there is really no lower dose.

It's a one-dose medication. And I don't feel like they're really appropriate for a dose reduction but I'm not sure. Do I document that or have the doctor document that? And at what point would a gradual dose reduction be appropriate?

Dr. Chad Worz: Sharon, I'll take the first part of that question. Part of the reason for the good documentation and the tracking of behaviors is for just scenarios like this where you have a patient that might have a chronic progressive disease where the medical team feels like there is a potential risk of lowering the dose.

And sometimes we have medications with FDA indications like in this case where there is only really one dose that's effective. And in those cases, I think it would be appropriate to properly document the disease that they have, the symptom resolution that they're getting and the fact that there is no dose to go to as a – as a reason to not do the GDR, to call it a clinical contraindication.

To speak to at what point it may be worth trying to take a patient off of a medication in that scenario, I think I would – I would defer to Dr. Grossberg or Dr. Eastman or Susan to give some insight on that.

Dr. Alexis Eastman: Yes. Hi. This is Alexis Eastman. I can – I'll pick it up there. You know I think you would want to have the doctor's input at that – at that point in time included in the documentation as to why this is medically indicated and why it remains appropriate. This is a sort of a difficult area if you see a progressive

disease. And you would need clear documentation both from you and from the physician, then, to say, “This medication is necessary. There’s really nowhere else to go with this and really no way to take this back.”

And I think that that would be a partnership in terms of documentation and medication appropriateness. So, I wouldn’t fly solo on this. I would definitely have the doctor back you up.

Sharon Clackum: Perfect. Thank you.

Dr. George Grossberg: Yes. Let me just add to that. Yes. I was going to add to that – this is George Grossberg – that the scenario of psychosis in Parkinson’s disease has been kind of classified as a special area of kind of chronic or longer-term psychosis. So, longer-term treatment, because of what we know about the natural history of psychosis in Parkinson’s disease, would be warranted.

Sharon Clackum: Thank you so much.

Operator: The next question will come from the line of Timothy Beittel.

Timothy Beittel: Hi. This is Timothy Beittel. I’m the Chief Medical Officer with Liberty Healthcare, a skilled nursing chain in North Carolina. This is in response to part of the case presentation for Dr. Eastman, but, of course, anybody could chime in.

I was wondering if you would comment on the choice to include a urinalysis, urine culture, checking for urine infection in this patient, although I think most of us probably would, in fact, do that. It’s a – it’s difficult these days with antibiotic stewardship initiatives and the fact that most decision supports for evaluating for UTIs would say that in the absence of a fever or any localizing urinary symptoms that that may not be appropriate to check the urine.

Dr. Alexis Eastman: Yes. I think you have brought up an excellent point – this is Alexis Eastman; sorry – and a very – an area of great ongoing discussion, as I’m sure you’ve all experienced. I am a medical director of a long-term care facility, and I think we’ve all had ongoing discussions about when is it appropriate to get a urinalysis.

And, certainly, by the updated McGeer criteria, Mrs. Jones does not meet those criteria. She does have an acute change in behavior, which gives you a little bit of wiggle room but not the full criteria. However, there is ongoing evidence that when you’re trying to rule out a delirium, if someone were being sent to the hospital, for example, to rule out a delirium, you would need to do a full infectious workup irrespective of other symptoms. And, so, a urinalysis would be done.

So, it’s a very tricky situation. And I would say that this is where documentation is especially important, right, to say, maybe even acknowledge, while not meeting current revised McGeer criteria, these are the criteria the patient does not and, given that we are evaluating for delirium versus dementia-related psychosis, full delirium workup is indicated – something along those lines.

It really is about explaining the rationale and the thought process to be good stewards of both infection control and to prevent patients suffering from dementia-related psychosis. So, that – my answer is always excellent documentation, more or less, to justify your thought process.

Dr. George Grossberg: Yes. I might just add to that, Alexis. This is George Grossberg. It is a significant area of controversy. I think part of the problem is that when you have an older adult who is cognitively impaired, they're not going to be able to complain of the usual things that someone with an active UTI complains of.

They're not going to complain of dysuria, pain or discomfort or frequency. They might already have frequency because of their dementia in the absence of infection. Because they're elderly, they may have a blunting of their febrile response. We know that that can happen in older adults. So, a lot of the usual markers for an active UTI may not be there.

However, if we have a history of UTIs, especially a history that every time this patient gets a significant urinary tract infection, they become delirious, they become agitated, confused and so on, that would, obviously, make it, to me, very, very important to check their urine. But, again, documentation, as you said, is very, very important.

Timothy Beittel: Thank you.

Operator: Our next question will come from the line of Laura Junker.

Laura Junker: Hi. I'm a director of nursing at a long term care facility in Minnesota. And I actually – someone just recently from the last one to three weeks started talking about hearing voices. So, she could hear voices behind the walls. She could hear her sister's voice often.

And when asked what they said, she would say, "Well, they're just talking about what I can do for myself, how I can take care of myself" and that – but they also told her that, for whatever reason, she was going to be going to prison.

And she also started talking about she thought that she saw her sister in the hallway. And the night before she went into the hospital, she said that she was sitting on a couch and she felt a burning in her seat and two men came in with her when she went to the bathroom and they said, "Yes, it's red and you have burns on your bottom."

But – so, she went in and they did a full workup, a CT, an MRI, a UA, all of her labs and everything so far has been within normal limits. Now, she says the voices are still there. This is Sunday. So, today – yes, Tuesday – the voices are still there. They just talk about her and how she is doing and what she can do for herself. She is 76 years old, has never ever had a history of auditory or visual hallucination.

Dr. George Grossberg: Does she have dementia?

Laura Junker: No. She had been more forgetful in the last year. But she has also been isolated from her family.

Dr. George Grossberg: Yes. Let me just comment about that. I think you're bringing up a really, really important point, which – we saw quite a bit of this during the COVID lockdown. So, now, things are getting a little bit better. I know that we're returning back to doing our in-person nursing home rounds from virtually basically doing only virtual rounds for the past year.

But, during the COVID lockdown, a lot of older adults, particularly those that were beginning to have some memory or cognitive issues, often begin to show a variety of behavioral and psychological symptoms of the type that we would see in people with maybe even early dementia.

And keep in mind that this woman who may be starting to have cognitive issues may be at the early stages of dementia and you're looking at some of the dementia-related psychotic symptoms, which are exacerbated or have been maybe by the lockdown, by social isolation, not being able to hug her family, not being able to have group activities, not being able to have group meals. It's been really, really hard for our long term care residents.

So, now, as we begin to open up, you may see an improvement with that, with the activity, with engagement, with family. You may begin to see an improvement in her psychotic symptoms. If you don't, I would definitely recommend doing – if you haven't already done – a more formal dementia workup, although it sounds like you have.

But at least do a good cognitive screening to see if she may be in the early stages, maybe having either prodromal or kind of the early stages of a dementing process like Alzheimer's disease, which can be accompanied by psychotic features. Keep a close eye on the psychosis.

I would not treat pharmacologically. I would think about non-pharmacologic interventions unless the psychotic symptoms became severe and the non-pharmacologic approaches were not working, at which point you may need to use pharmacotherapy.

But it's a very important case and I think really highlights the tremendous impact that the COVID isolation has had on our seniors in long term care. It's been absolutely devastating, particularly for vulnerable older adults with the beginnings of cognitive impairment or who already have had a diagnosis of dementia.

Laura Junker: Would it be possible that this would be related to severe depression from being isolated for so long?

Dr. George Grossberg: Absolutely, absolutely. So, as you saw in the diagnostic criteria that the International Psychogeriatric Associated developed, one of the things to consider would be psychiatric illness that can also be accompanied by psychotic features. So, it's a possibility.

What's interesting, though, is the psychosis that comes out of depression. And I think, as you know very well, psychotic depression is also more common in older adults, in people in later life, usually the delusions, the firm false beliefs that they have. And almost always it's delusions – they're not hallucinating – with depression. It's really rare.

The delusions are kind of derogatory. They are very negative. “I’m a terrible person. I shouldn’t have done what I did. I should have done better in my life.” They’re kind of – they’re kind of coordinated with the mood. So, they’re very different in nature than these psychotic symptoms that you see in a dementia. So, that has to be definitely part of the differential diagnosis. Yes.

Laura Junker: Okay. Thank you.

Operator: As a reminder, to ask a question, press “star” followed by the number “1” on your touch-tone phone. To remove yourself from the queue, press the “pound” key. Remember to pick up your handset before asking your question to ensure clarity. Once your line is open, state your name and organization.

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Our next question will come from the line of Krista Haglund.

Krista Haglund: Hi. My name is Krista Haglund. I’m a pharmacist with Daiya Healthcare. And I just had a question about patients with dementia-related psychosis. Once you’ve exhausted non-pharm interventions, you’ve ruled out possible other causes for behaviors and such, how do you go about choosing an atypical antipsychotic or anti-depressant? And, specifically, which ones have you seen to be the most effective?

Dr. George Grossberg: Alexis, do you want to jump in, or you want me to?

Dr. Alexis Eastman: I will. I’m going to defer to you on this. I have my opinions.

Dr. George Grossberg: Okay.

Dr. Alexis Eastman: But, I could be …

Dr. George Grossberg: Yes.

Dr. Alexis Eastman: I would say that you probably have a better opinion.

Dr. George Grossberg: Yes. I have a stock answer. I am just kidding. But I actually thought it’s a great question and it’s really, really important. So, once we’ve exhausted the non-pharmacologic options and the psychotic symptoms are impactful, they’re really making a difference, impacting the quality of life of the patient, of the resident, of the caregivers, of the family and so on, then we think about pharmacotherapy.

And we want to keep in mind that at the present time, we don’t have any FDA-approved treatments for dementia-related psychosis. Everything is off-label. Okay? So, when we look at the state of antipsychotic

medications, we are generally favoring the newer drugs, the atypicals, versus the older drugs like haloperidol and so on because they have a better side effect profile.

But, in the side effect profile is the answer, I think, to the really good question that you're asking. And that is if we assume that the atypical antipsychotics, when used in the appropriate circumstance in the appropriate dose for the appropriate length of time are equivalently effective – and I think they pretty much are – then we pick the drug based on what side effects we'd want or what side effects we don't want in that older adult with dementia-related psychosis.

So, for example, if you have a lot of agitation, if the psychotic symptoms are triggering agitated or even aggressive kind of behaviors, we may want an atypical antipsychotic that has a bit more of a calming effect. On the other hand, someone that's more apathetic, who's not agitated where we don't need that kind of calming effect, we would want something that is not sedating.

A really, really important consideration is to keep in mind whether this patient may have Lewy body dementia because if they may have either Lewy body dementia or Parkinson's disease dementia with psychotic features coming out of that, we want to avoid the high-potency antipsychotics, medications that can exacerbate Parkinsonism.

Those would be – in the old days would be something like haloperidol. More recently, it'd be something like risperidone, okay, which is a high-potency drug, which means you have to give less milligrams of the drug to get good antipsychotic effects.

So, bottom line answer is we pick the drug based on what side effects we want and what side effects we want to avoid in the particular patient. And then, of course, start low and go slow but go. So, we want to start at the low dose, gradually increase but get to a therapeutic dose for the 85-year-old. So, it's important that we know what the therapeutic range is for that age of patient with their comorbid medical problems.

Krista Haglund: Yes. I completely agree. Thank you. I would add kind of two more – two more (inaudible), which is, one, sometimes I am thinking about side effects to appetite. So, a lot of my patients tend to have decreasing appetite when these things are going on. And some of the antipsychotics tend to make people want to knosh a little bit more, and that can be helpful.

Dr. George Grossberg: That's true.

Krista Haglund: I also – I also think that the timing of when you dose them is very important given that you're aiming for a certain side effect. So, if you're kind of choosing your antipsychotic which is (inaudible) based on its sedating properties, you're going to want to dose that in the evening, not first thing in the morning. And try to work on these low doses but at the appropriate time as well.

Dr. George Grossberg: Yes. I agree. I think you asked a rhetorical question because I think you already know more of the answers than we do. So, those are great points. Thank you.

Susan Scanland: I'd like to chime in. This is Susan Scanland. Krista, something that I do in my practice in long term care – prior to initiation of antipsychotics, I will be sure first of all ruling out the depression if there is

vegetative signs or if they test positive on the geriatric's depression scale – I will be sure that I am treating them with – I usually with an SSRI or an SNRI. And sometimes, that alleviates – of course, if they had a psychotic depression, that could improve the psychosis – or just treat the vegetative signs until they get better.

Also, another thing, as everyone has talked about before, ruling out all the delirium first and treating the cause for that before starting an antipsychotic product – but, another thing that I try to do is – for as far as maximizing what is FDA approved already, looking at cholinesterase inhibitors and then VA antagonists because what I found and what the research has shown over the last 15 or 20 years – when you maximize those meds to their highest level – I've actually very rarely used antipsychotics if I treated the dementia – the dementia – I'm sorry – the depression, the delirium and then maximize the treatment of what's already approved. Often, I can prevent having to go to an antipsychotic.

Of course, that doesn't help like in our case with Mrs. Jones who really did need help because she was severely agitated. But, in a person that you just want to sort of prevent it, it's definitely worth a try.

Krista Haglund: Great. Thank you so much.

Leah Nguyen: Thank you.

Dr. Chad Worz: Just – I'll go ahead and join the parade of chiming in. But, just to reiterate what both Susan and Dr. Grossberg said, this is a very patient-specific, patient-centered decision, whether it's what non-pharm approach is going to work or what antipsychotic or psychoactive agent I'm going to choose is going to work. It's really based on the individual patient.

And one of the reasons that we have six protected classes – one of those protected classes is antipsychotics because we want to make sure there is access to all the medications in the class for the cases that somebody might need one medication over another because of a side effect profile, because of a mechanism of action, because of the other medications that might be on their profile and trying to walk the tight rope of providing a medication that's not going to disrupt the other medications.

So, I just wanted to reiterate that that's a very important point to glean from this. It's that we make decisions about people that are sitting in front of us and their characteristics, not so much reaching for a particular medication that we think works in everybody.

Leah Nguyen: Thank you. Blair, we'll take the next question.

Operator: The next question will come from the line of Barbara Anthony.

Barbara Anthony: Hi. I'm Barbara Anthony. I'm with the Dementia Partnership Coalition. And first of all, I want to say I've heard some great information today. One of the things that we have identified is when – and we talked a lot about delirium – is when residents with dementia are sent to an acute psychiatric setting and they are – it's determined that they do have maybe a UTI, the psychiatrist will order an antipsychotic.

When the resident is returned to the nursing home, they have a diagnosis typically of psychosis and they're on an antipsychotic. The attending physicians are reluctant to have any – make any alterations in that – in the use

of an antipsychotic. They feel like that if a psychiatrist ordered the antipsychotic that they are the ones that should be taking them out of the medication.

So, a resident who actually was confirmed with delirium, had a UTI and that was not identified, that was not diagnosed, that no diagnosis was given for the delirium, the antibiotics has done its work, they no longer have the delirium but, now, they are – they have an actual psychosis diagnosis which is generating the conversation.

So, I didn't know if there was some way – and we kind of shared that on our calls – CMS calls – if there was some way that someone can assist in helping these attending physicians in these nursing homes who do not feel comfortable with adjusting these antipsychotics, even putting them in gradual dose reduction.

So, we reached out to some of the psych facilities we've been working with and asked them if they knew it was delirium to maybe send them back with an order to initiate a gradual dose reduction especially when the resident comes back and they're no longer exhibiting any of the psychotic behaviors. So, kind of helping out with that particular situation when the residents with dementia are having delusions – that can be normal.

And the dementia world – they can see their dead spouses; they can see children that they used to teach. And you're training the staff on not all delusions are bad. It's only when they become harmful in nature – and you have described a number of cases – that then they – it requires some type of intervention. And when non-pharmacologicals don't work, then – if you put that result in a lot of the times going to a psychiatric setting. So, I just want to kind of get some feedback on that.

Dr. Alexis Eastman: Yes. Hi. This is (inaudible). I think you bring up some really excellent points. It is – it is very difficult; you know I think – I am – I am a geriatrician – kind of a primary care geriatrician with a nursing home and memory interest and I have been lucky enough to have additional training in these symptoms and the management of them.

But there are many physicians who do not have that training. And that is a real barrier and a difficulty towards getting appropriate care, especially in terms of gradual dose reduction. And as you had pointed out, collaborative care with psychiatric partners is really key.

And, so, your approach is really valuable. I do the same thing. I contact my colleagues in psychiatry when there is a question I have about a medication. So, really encouraging that partnership is very important going forward.

And I would say it's one of the most important things we can do because we need to have increased access and education for all providers so that they feel that they are able to make a supportive decision to help patients struggling with these symptoms.

And in terms of the delusions, I think you highlighted a very key point, which is that, yes, indeed, if it is not causing a functional deficit or a harm, then they don't necessarily require pharmacologic or even non-pharmacologic intervention. I heard Dr. Grossberg about to say something, so I'll defer to you.

Dr. George Grossberg: Yes. And I was going – and I agree with 100 percent, Alexis. I was going to add, though. First of all, you bring up a lot of good points, as was mentioned. The issue is of transitions of care,

transitioning from, let's say, the nursing home or long term care to the hospital to maybe a geriatric psychiatry unit and then from the hospital back to the facility, assuming that that facility will take the patient back who has had significant behavioral issues. That's another ball of wax unto itself.

But a lot of facilities don't have psychiatric consultants. And we can't really go kind of psychiatrist to psychiatrist to really say that while this patient was in the hospital and they were acutely delirious, they were psychotic, they were agitated, they were out of control and we recommended in the hospital an antipsychotic for acute safety issues, for behavior.

But now that the delirium is resolved and they are no longer psychotic, why should that – or agitated and out of control, why should that antipsychotic medication be continued in the long term care environment? It may not be needed.

So, we need to kind of get that message across. And it's – as you pointed out, it's very difficult because a lot of primary care doctors and – let's face it, in the long – in the long term care scenario throughout the United States, we don't have people, Alexis, like you who are trained geriatrician primary care folks. We have primary care physicians who don't have a comfort level with antipsychotic medications.

And because of that, they're very reluctant to make changes, even though in the scenario that you described, obviously, what I would be doing as a consultant geriatric psychiatrist to the nursing home would be to say, "Hey, I'm not sure we need this antipsychotic anymore. Let's begin gradually to wean the person off because they needed it in the hospital when they were delirious and psychotic and out of control, but now that we've recognized and treated the underlying cause we probably don't need to be on an antipsychotic anymore." So, these are major challenges for all of us throughout the country.

Susan Scanland: And here is another good point, too.

Leah Nguyen: Thank you. Blair, we'll take the next question. Sorry. Go ahead.

Susan Scanland: Okay.

Leah Nguyen: Go ahead.

Susan Scanland: I just want to make one additional point on that. Dr. Grossberg was one of the task members on the development of the International Psychogeriatric Association. So, if you go back to like slide 13, you really have to have had – under D, you have to have the symptoms for at least a month to have dementia-related psychosis. So, if this patient just got delirious when the UTI became – came on, they probably did not have it more than a month. And …

Dr. George Grossberg: Right.

Susan Scanland: And then, in that criteria, it also says under F it has – they cannot be exclusive to a delirium. So, all you have to do is share this with a physician and say, "Here's the – here's the criteria to the true psychosis." It can't be delirium.

Dr. George Grossberg: Right.

Susan Scanland: And you have to have it at least a month. So, use those criteria to educate …

Dr. George Grossberg: Right.

Susan Scanland: … physicians. And Dr. Grossberg and his team have done an amazing job with getting those criteria out. And that's why they're there for.

Dr. George Grossberg: Thank you for that. Thank you for that. I think education is the key. And you're right. You're absolutely right. There's a difference between kind of long-term psychotic symptoms, whether daily or intermittently, versus the acute psychosis.

And, of course, the emergency situation where the patient is out of control and, God forbid, may harm themselves or harm somebody else – that would be an indication for – at least acutely for pharmacotherapy to buy us time to figure out what the cause is.

Susan Scanland: Yes.

Barbara Anthony: Well, I would just like to add that in a lot of the nursing homes is – I'm seeing this across the country – there are multiple attending physicians. There might be one attending for 15 residents and another one for 25 residents. So, there isn't one consistent attending physician in these scenarios. But our challenge has been just getting a comfort level.

And I really appreciate the things you all are saying because I think it is a problem that needs to be addressed maybe even from the CMS world with the psychiatrists because they are licensed. They maybe can put some guidelines out that could help psychiatric settings with shared – being able to at least recommend gradual dose reduction to the attending, so it puts them in that world that they feel comfortable doing that. And that's my point.

Susan Scanland: Yes. That's a good point because …

Leah Nguyen: Thank you. Blair, we're going to – we're going to take the next question.

Susan Scanland: Okay. Sure.

Operator: The next question will come from the line of Amber Russell.

Amber Russell: Hi. I'm Amber Russell. I am an educator in Overland Park, Kansas. So, I currently am hearing a (inaudible) conversation and I – my first thought is going to pseudo-dementia, which is usually caused by depressive symptoms. I don't know a lot about it.

I just heard some webinars about a few things about it. What, you guys, are your opinion on this pseudo-dementia? And how can we get our nurses and everybody to really kind of recognize that before we start shipping our patients out for no reason?

Dr. Alexis Eastman: Yes. So, this is Alexis Eastman. It's an – it's an excellent question. Pseudo-dementia is sort of a broad category of correctable conditions that can mimic dementia, right – so, hypothyroidism or delirium or all of these things we sort of have been talking about as been part of the diagnostic criteria for dementia-related psychosis also hold true in the diagnosis of dementia itself.

And, so, I think one of the things that's really important is to know that you can't diagnose dementia without a formal evaluation. Right? There needs to be a practitioner – a medical practitioner who looks through a person's clinical presentation, does the workup necessary to eliminate pseudo-dementia from the differential diagnosis and then formally diagnose someone with a dementia and, ideally, what type of dementia.

So, it is – you are correct. It is not sufficient to say, "Oh, that someone is forgetful. They must be getting dementia." Dementia itself is a formal diagnosis which must be made by a medical practitioner. So, I think if you and your staff and other people in your staff are struggling with when to draw that line and what are the criteria, then seeking out available CME on things like the diagnosis of dementia would be really valuable as group learning but also knowing that these are diagnoses that must be made by a medical practitioner and cannot just be simply presumed. It's very important.

Amber Russell: Right.

Dr. George Grossberg: Yes. Let me – yes. I would just add to that, Alexis, that there is a term that I like a lot better than pseudo-dementia. And that's called the dementia syndrome of depression, recognizing that if you're…

Amber Russell: That's what I was wondering.

George Grossberg: Yes.

Amber Russell: I'm sorry. I apologize for interrupting.

Dr. George Grossberg: No. You're not interrupting. You're fine. So, it's a recognition that if you're 85, you're 90 years old and you're significantly depressed, you are going to have cognitive impairment that may not have anything to do with dementia that may be coming from your depression.

So, if you do the cognitive testing, a significantly depressed older adult because of depression is going to have difficulties. They're not going to score very well on their Saint Louis University Mental Status, the SLUMS, or the MoCA or the BIMS or any of the cognitive testing instruments.

But the recognition is also that if the only thing that's been causing the impairment has been depression, once we diagnose it and appropriately treat it, then the individual can get back to a good, a normal cognitive baseline.

If it does not fully reverse, then there may be other factors going on as well. But it's really to teach us that depression can be so impactful in the older adults that it could actually present with dementia-type features that are reversible once we recognize the cause and treat it appropriately.

Amber Russell: Right. So, that's what I'm wondering. It's how are we – how are we going to teach this to others as far as – because I know that the depression is what's bringing it on. And if they're coming to us with a diagnosis of dementia and being put on an antipsychotic and that antipsychotic is causing some …

Dr. George Grossberg: Okay. Yes. No, I think – I think we'll leave that to Michele, the teaching part. Michele, that's where you guys come in. And I think that's another great program to do.

It would be to look at the many different underlying causes of cognitive impairment in 85-year-olds that are not related to dementia, okay, whether it's underlying hormonal issues, whether it's depression, overwhelming anxiety. Even lockdown – COVID lockdown presented with dementia-like symptoms in non-demented older adults.

Amber Russell: Yes. They sure can.

Dr. Alexis Eastman: And I would jump in that the education is not just on the diagnosis. But I think what I hear you saying is how do we advocate for our patients who come to us with this sort of pre-set diagnoses that we would like to get re-evaluated.

And that's a thorny problem, I think. I don't – I don't know that I have any good answers for you. But I think that that is – it's true. There needs to be a place for patient advocacy in ensuring that they have been appropriately diagnosed.

Amber Russell: Yes.

Dr. Alexis Eastman: And I think – I think maybe that would be a great upcoming session.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 33. We hope you will take a few moments to evaluate your experience. See slide 33 for more information. An audio recording and transcript will be available in about two weeks at go.cms.gov/mln-events.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on dementia care. Have a great day, everyone.