

Behavioral And Psychological Symptoms of Dementia: Diagnosis, Treatment Options and Regulatory Considerations

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Disclosures

- Speaker's Bureau, Otsuka and Lundbeck Pharmaceutical for Rexulti.
- Speaker's Bureau, Alpha Cognition Inc. for Zunveyl.

Learning Objectives

- Attendees will become proficient in evaluating the various presentations of behavioral, psychological and neuropsychiatric symptoms associated with dementia.
- Attendees will be able to then accurately document through diagnostic coding the identifiers for these symptoms and improve their skills in implementing a treatment plan including pharmacological, behavioral, and environmental treatment strategies.
- Attendees will develop an effective clinical threshold for when to use medications for associated symptoms in elderly patients with dementia, and become aware of the benefits and limitations of these medication choices.
- Attendees will understand how to navigate the Center for Medicare and Medicaid Services policies and regulations regarding the use of psychotropic medications.

ICD-10-CM Codes for Dementia

- F01. – Vascular Dementia (include medical I-code for medical cause of the dementia)
- F02. – Dementia Classified Elsewhere (include medical G-code for the type of dementia)
- F03. – Dementia Unspecified/NOS (does not require a second code)

Severity of Dementia mild (A), moderate (B), and severe (C)

ICD-10-CM Codes for Dementia Associated Symptom Identifier

- 11 – with agitation
- 18 – with behaviors (disturbances of sleep, eating, social, sexual, etc.)
- 2 – Psychotic Disturbances
- 3 – Mood Disturbances
- 4 – Anxiety Disturbances
- 0 – No Disturbances

If Demented and Delirious use a dementia code and F05 for Delirium

Mood Disturbances in Dementia

- Includes the spectrum of depressed and manic moods.
- Look for a reversible cause (environmental, social, or medical).
- Diagnose Adjustment Disorder or Major Depression if it fits and helps further support your interventions.
- Primary medication intervention will be antidepressants or mood stabilizers.
- Behavioral interventions are important in all phases of treatment.

Antidepressants

- SSRIs, SNRIs, DNRI, TCAs and Glutamate Modulator
- In refractory patients, try to switch classes of antidepressants or use augmentation strategies.
- No clear understanding in dementia how long to treat with antidepressants or if relapse rates rival Major Depression.
- Apathy Syndromes can overlap with the mood identifier but can require different treatments and have worse outcomes.
- Pseudobulbar Affect requires accurate diagnosis and different treatment.
- Pharmacogenomic Testing

Anxiety Disturbances in Dementia

- Often related to interpersonal or environmental stress.
- May predate the onset of the dementia.
- Antidepressants work but not quickly.
- Benzodiazepines work quickly and carry more risks.
- Other options include Buspirone, Trazodone, Hydroxyzine.
- Antipsychotics

Psychotic Disturbances in Dementia

- Driven often by the amount of confusion and misinterpretation in the dementia with a very fluctuating course.
- Other times the delusional network is fixed and inflexible which is much harder to influence.
- More common presentation in Lewy Body and Parkinson's Types.
- Look for prior mental illness which will affect medication dosing and choices.
- Antipsychotic medications have a significant role in resolution of these symptoms.

Behavioral Disturbances in Dementia

- Sleep
- Eating
- Sexual Activity or Interest
- Socialization Change
- Personality Change (mean, bossy, apathetic, impulsive)
- Can involve secondary gain.
- In many cases, the medication choice targets the symptom.

“It doesn’t look illogical; it looks different and dysfunctional”

Agitation in Dementia

- The occurrence of goal-oriented activity in a patient without any logical goal.
- The activity is distressful for the patient and or caregivers.
- It can change abruptly and not have a theme to it (in contrast to behavioral problems in dementia).
- It can look like delirium and needs medical factors controlled or ruled out.
- It can represent its own pathophysiology inside the dementia once it takes hold (a disease within the disease at any stage).

Presentations of Agitation

- Physical Aggression – hitting, pushing, fighting, throwing things.
- Wandering – exit seeking, sleeping in the wrong place.
- Taking and Misplacing Things with Repetition.
- Restlessness – repetitive mannerisms, rocking, picking.
- Verbal Impulsivity – yelling, repeating negative statements or making illogical noises.

BPSD and Agitation

- Up to 60% of community based dementia patients have one or more symptoms.
- Up to 90% of nursing home dementia patients have one or more symptoms.
- Symptoms can come and go and change as the illness progresses.

Impact of BPSD and Agitation

- Increases healthcare expense.
- Increases caregiver burden.
- Increases the progression to placement.
- Increases the incidence of harm to others.
- Increases incidence of harm to self.
- Increases accidents resulting in physical disease progression.

Treating BPSD and Agitation

- Correct any reversible medical factors.
- Simplify the medication combination (some medications can exacerbate the presentation).
- Involve all parties that know the patient best to determine what worsens the symptoms and what makes it get better.
- Consider the use of psychotropic medications.

The Role of Antipsychotics in Dementia

- Impulsive Aggression
- Psychosis
- Mania
- Refractory Depression
- Anxiety and Obsessive Behaviors
- Insomnia and Weight Loss
- Agitation

Antipsychotic Medications

Haldol (haloperidol)	Invega (paliperidone)	Vraylar (cariprazine)
Prolixin (fluphenazine)	Clozaril (clozapine)	Saphris (ascenapine)
Navane (thiothixene)	Zyprexa (olanzapine)	Nuplazid (pimavanserin)
Thorazine (chlorpromazine)	Seroquel (quetiapine)	Fanapt (iloperidone)
Mellaril (thioridazine)	Abilify (aripiprazole)	Rexulti (brexpiprazole)
Risperdal (risperidone)	Geodon (ziprasidone)	Caplyta (lumateperone)
	Latuda (lurasidone)	

Long Acting Injectables: haloperidol, prolixin, abilify, paliperidone, risperidone

Antipsychotic Medication Subclasses

First Generation

- Haldol
- Prolixin
- Navane
- Thorazine
- Thioridazine

Second Generation

- Clozaril
- Zyprexa
- Seroquel
- Saphris
- Risperdal
- Invega
- Latuda
- Geodon

Third Generation

- Abilify
- Rexulti
- Vraylar
- Caplyta
- Nuplazid

Box Warning for Antipsychotic Medications

- Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at increased risk of death.
- Pooled data from 17 studies averaging 10 weeks duration concluded that the rate of total deaths increased from 2.6% in placebo controls to 4.5% in patients receiving antipsychotic drugs.
- Causes of death were stroke, cardiovascular disease, and pneumonia.

Box Warning for Antipsychotic Medications

- The newest antipsychotic medications have never been studied in dementia-related psychosis but are included in the warning.
- In the FDA studies on the newest antipsychotic medications, deaths did occur in elderly subjects, but were not correlated to the drug or its dosing.
- Data was collected from 2005 to 2008 and subsequently never fully replicated again.

Mild to Moderate BPSD and Agitation Medication Treatments

- Confirm that non-pharmacological treatments have failed.
- Try other medication classes (antidepressants, cognitive enhancers, anti-anxiety, mood stabilizers, FDA approved choice and others).
- Use the antipsychotic medication with least potential for side effects which leans toward the third generation medications like Abilify and Rexulti (unless you want side effects).

Emergent Treatments of Agitation

- Need options for IM administration (Lorazepam, Haldol, Zyprexa or Geodon).
- Often are short term treatments so side effect profile is less important.
- The doses and administration schedule you start with will often need to change by week two.
- Although Haldol is a reasonable choice in acute agitation or delirium, it is now believed neurotoxic to healthier patients.

Final Thoughts on Antipsychotic Medications in BPSD and Agitation in Dementia

- Use cautiously and monitor carefully.
- Be expecting to have to change medication choice or dose after the first week or two.
- Switch upon failed trial to a different acting chemical in the class.
- For the first treatment course of severe BPSD and Agitation continue some dose of the medication for one to three months before GDR (unless due to a clear trigger, now resolved).

Center for Medicare and Medicaid Services Updates on Psychotropic Medications in LTC

- Code of Federal Regulation 42 CFR 483.45 – applies most to hospitals and nursing homes.
- Additional Strength of F605 – “Patient/Resident right to be free of chemical restraint.”
- More attention to F758 – “Free of unnecessary PRN medications.”
- Care Compare 5-star rating for nursing homes – CMS sponsored website for public access to assess the quality of a nursing home from clinical measures (includes the percent of long stay residents in a NH on antipsychotics).

How to Avoid F-Tag 605 in Documentation

- Psychotropic medications are to be used for specific symptoms in medical disease (even if off-label use is needed) and at lowest possible doses.
- Non-pharmacological (“less restrictive”) interventions must have been tried and failed or were contraindicated.
- The use of the medication is NOT the cause for a negative “change in condition” or day time sedation of the patient.
- Patient or responsible party consents to the medication.
- Clinician monitors side effects and efficacy at intervals.
- GDRs are addressed (attempted, failed, or contraindicated).

Gradual Dose Reduction Guidelines For Psychotropic Medications

- Within the first year, must attempt a GDR in 2 separate quarters, separated by one month.
- After year one on a maintenance psychotropic medication, must attempt a GDR yearly.
- There must be ongoing assessment of the need and safety of the psychotropic medication including GDR at quarterly care plan meeting of nursing home staff.

PRN Usage Guidelines for Documentation in LTC

- Must indicate the medical reason the PRN is used and specify the exact duration of usage in the order.
- ALL antipsychotic medications written as PRNs must have a 14 day maximum stop order.
- To renew an antipsychotic as a PRN for longer than 14 days, the clinician must re-evaluate and write a new order.

Thank You for your Attention.

Any Questions?