

PACE

Pharmaceutical Assistance
Contract for the Elderly



Balanced information for better care

Caring for vulnerable elders

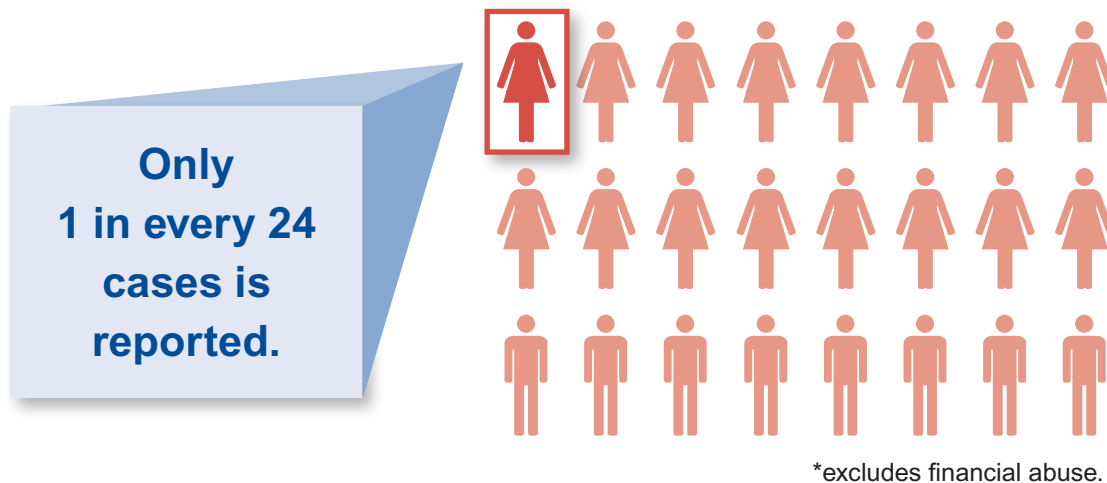
- Addressing elder abuse
- Managing dementia
- Supporting caregivers



Elder abuse is common and can cause substantial harm

The problem includes physical, emotional, and sexual abuse and can encompass neglect and financial exploitation.¹

FIGURE 1. Underreporting of abuse leaves elders vulnerable to harm. Only about 4% of cases* are reported to law enforcement or a state agency that serves elders, such as an Area Agency on Aging.²



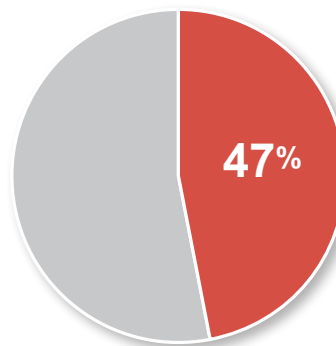
Elder abuse increases the risk of:

- mortality³
- disability⁴
- emergency room visits⁵
- hospitalization, including readmissions⁶
- nursing home admission^{7,8}

Patients with dementia are more vulnerable to abuse.⁹

Risk factors for abuse:

- increased severity of dementia
- violent behavior by the patient, such as acute behavioral and psychological symptoms of dementia (BPSD)
- caregiver depression



In one study, nearly half of dementia patients had been abused in the prior year.

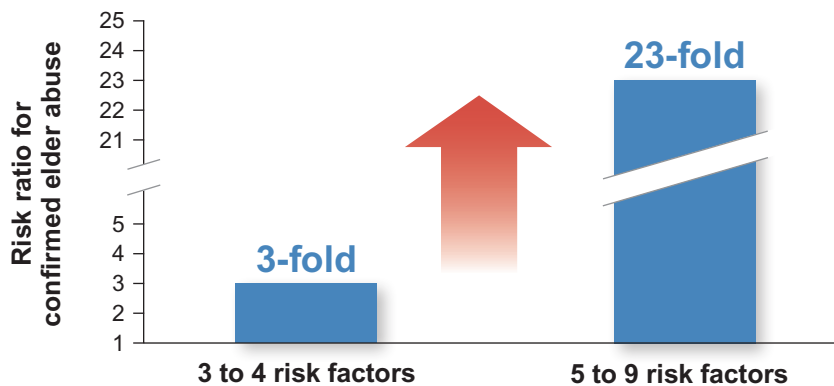
Patients and caregivers reported similar rates of abuse.

How to identify elders at risk for abuse

FIGURE 2. Specific factors predict an increase in vulnerability.¹⁰

Demographic:	Health-related:
<ul style="list-style-type: none">• age >80• female sex• non-Hispanic black race• income \geq\$15,000	<ul style="list-style-type: none">• \geq3 medical conditions• cognitive impairment (MMSE <23)• physical disability (e.g., difficulty with stairs)• depressive symptoms• limited social network (e.g., <2 visits/month from family or friends)

FIGURE 3. Compared to elders with 0 to 2 indicators, the prevalence of elder abuse is dramatically higher in patients with multiple risk factors.¹⁰



A short six-question screen can help identify the problem:¹¹



1. Are you afraid of anyone in your family?
2. Has anyone close to you tried to hurt or harm you recently?
3. Has anyone close to you called you names or put you down or made you feel bad recently?
4. Does someone in your family make you stay in bed or tell you you're sick when you know you aren't?
5. Has anyone forced you to do things you didn't want to do?
6. Has anyone taken things that belong to you without your OK?



If abuse is suspected, report concerns to the appropriate authorities. Document this suspicion and any evidence of abuse.

Cognitive impairment

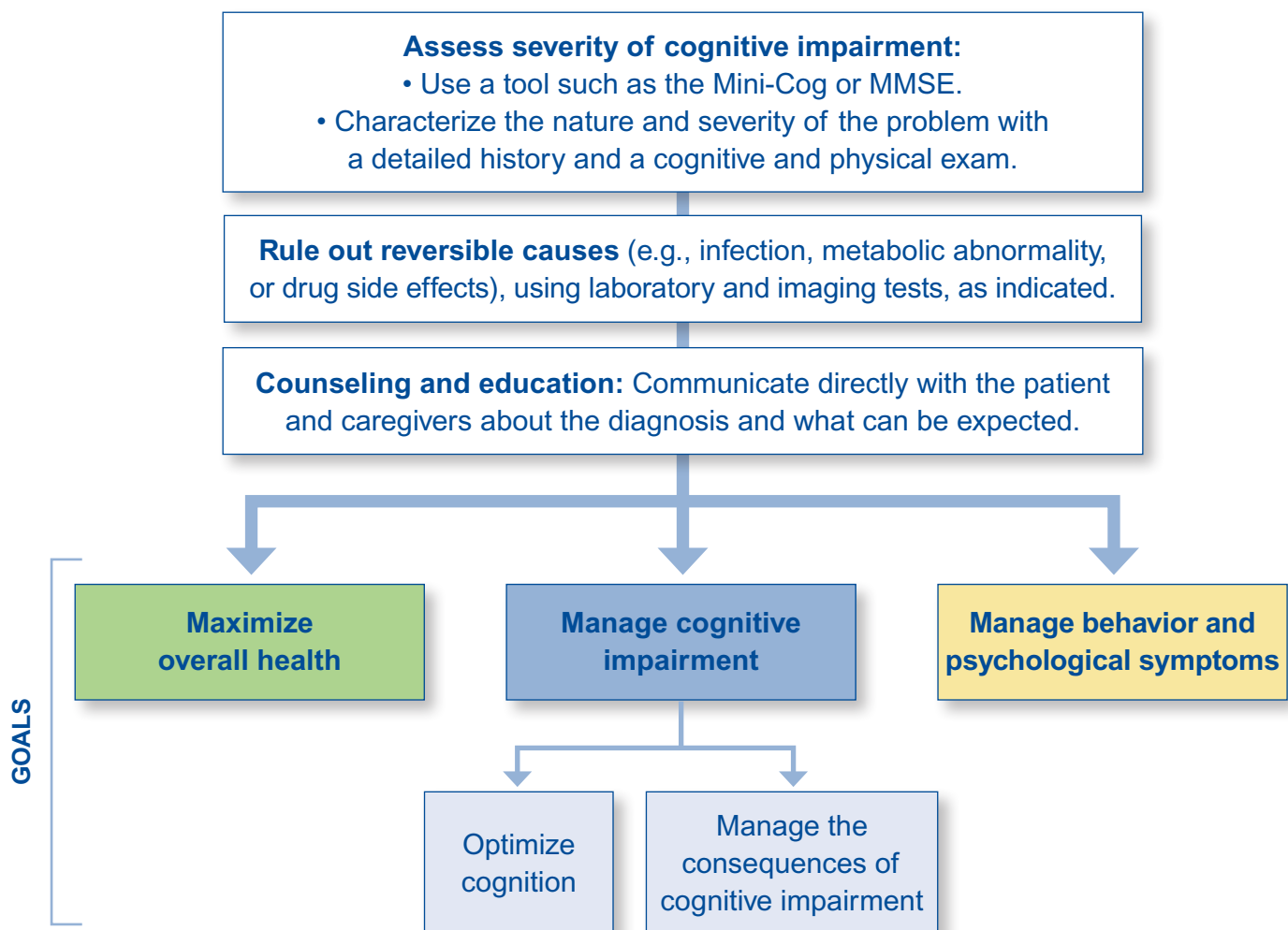
Integrated management of patients with dementia

Should I screen *all* elderly patients for cognitive impairment?

The U.S. Preventive Services Task Force does not recommend universal screening of all patients over 65.¹² It suggests testing only those with:

- a complaint of cognitive deficit by patient or family
- mood or anxiety symptoms
- increased risk of safety problems

FIGURE 4. A framework for managing patients with Alzheimer's disease and related dementias



Cholinesterase inhibitors and memantine offer limited help

These drugs may slow the rate of cognitive decline in some patients, but this benefit is usually modest and often time-limited.

FIGURE 5A. If a response occurs, it usually does so within 3 months of starting treatment. Any modest improvements that are seen generally diminish in 6-12 months in most patients.¹³

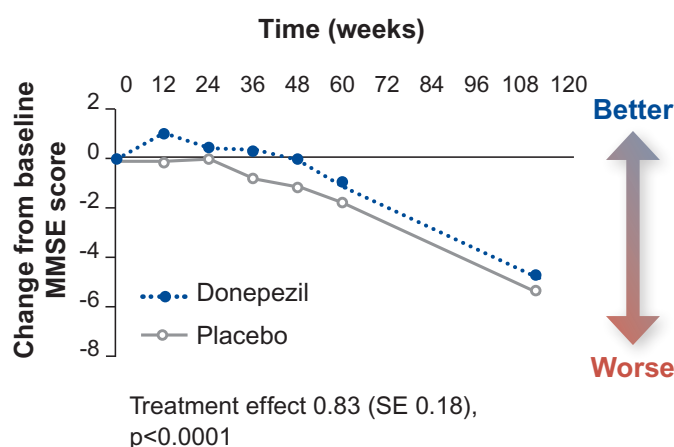
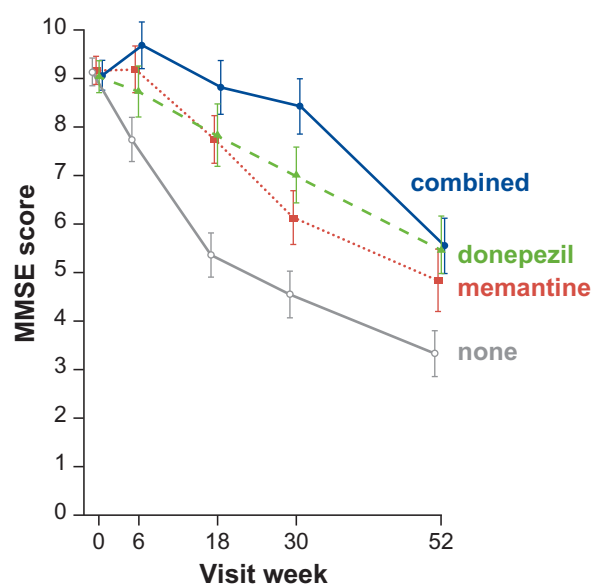


FIGURE 5B. Combining a cholinesterase inhibitor with memantine provides a small and transient advantage over each drug alone, and limited benefit over placebo.¹⁴



If a trial of a cholinesterase inhibitor or memantine is begun:

- 1 Start at a low dose and titrate slowly.
- 2 Monitor carefully for these common side effects:

cholinesterase inhibitors	memantine
—nausea, vomiting, diarrhea	—dizziness
—anorexia	—confusion
—dizziness	—headache
—cardiac arrhythmias	—hypertension

Throughout, weigh the drugs' efficacy against their common side effects. A trial off medications can help address whether they should be continued.

- 3 Reassess at 3-6 months to determine if the risk-benefit relationship warrants continued treatment.

A roadmap for managing dementia

	MILD COGNITIVE IMPAIRMENT (MCI) (MMSE usually >26)	MILD DEMENTIA (MMSE usually 20-26)
Clinical characteristics	<ul style="list-style-type: none"> • Impairment in memory and/or additional cognitive domains without loss of function in usual activities 	<ul style="list-style-type: none"> • Impairment in memory and at least one other cognitive domain. Complex activities reduced; social judgment usually intact
Education and counseling for patients and caregivers	<ul style="list-style-type: none"> • MCI is not always due to Alzheimer's Disease. • Approximately 12-15% of patients with MCI will progress to Alzheimer's Disease each year. 	<ul style="list-style-type: none"> • Apathy and irritability are common and may occur independently of depression. • Promote independence and stimulation. • Identify surrogate decision makers and discuss end-of-life care. • Pennsylvania requires reporting a diagnosis of dementia to the Department of Transportation.
Treatment options	<ul style="list-style-type: none"> • There are no convincing benefits of cognitive-enhancing medications at this stage of the illness. • Depression, anxiety, and irritability are common and may require treatment. 	<ul style="list-style-type: none"> • Consider a trial of a cholinesterase inhibitor. • Consider referral for cognitive training/rehabilitation if available.
Other referrals	<ul style="list-style-type: none"> • Clinical research opportunities exist for both MCI and dementia. Consider referring patients for such studies. 	<ul style="list-style-type: none"> • Involve a social worker or nurse practitioner with expertise in dementia or geriatric care. • Contact an elder care attorney for legal and financial planning.

1. Establish and reinforce daily routines surrounding eating, exercise, stimulating cognitive/social activities, and sleep.
2. Review the patient's medication list (including OTC and alcohol) for drugs that can worsen cognition.

MODERATE DEMENTIA (MMSE usually 12-20)

- Newly acquired information is rapidly lost, with the capacity to perform simple tasks usually retained; assistance needed for self-care; little independent function outside home
- Monitor caregiver stress.
- Educate caregivers to watch for triggers for agitation, “choose battles,” and avoid attempting to solve disagreements with logic.
- Consider a trial of memantine.
- Use non-pharmacological strategies for managing behavioral and psychological symptoms.
- Home services, a day program, or respite care may be required.
- Involve a social worker with expertise in dementia or geriatric care issues.

SEVERE DEMENTIA (MMSE usually <12)

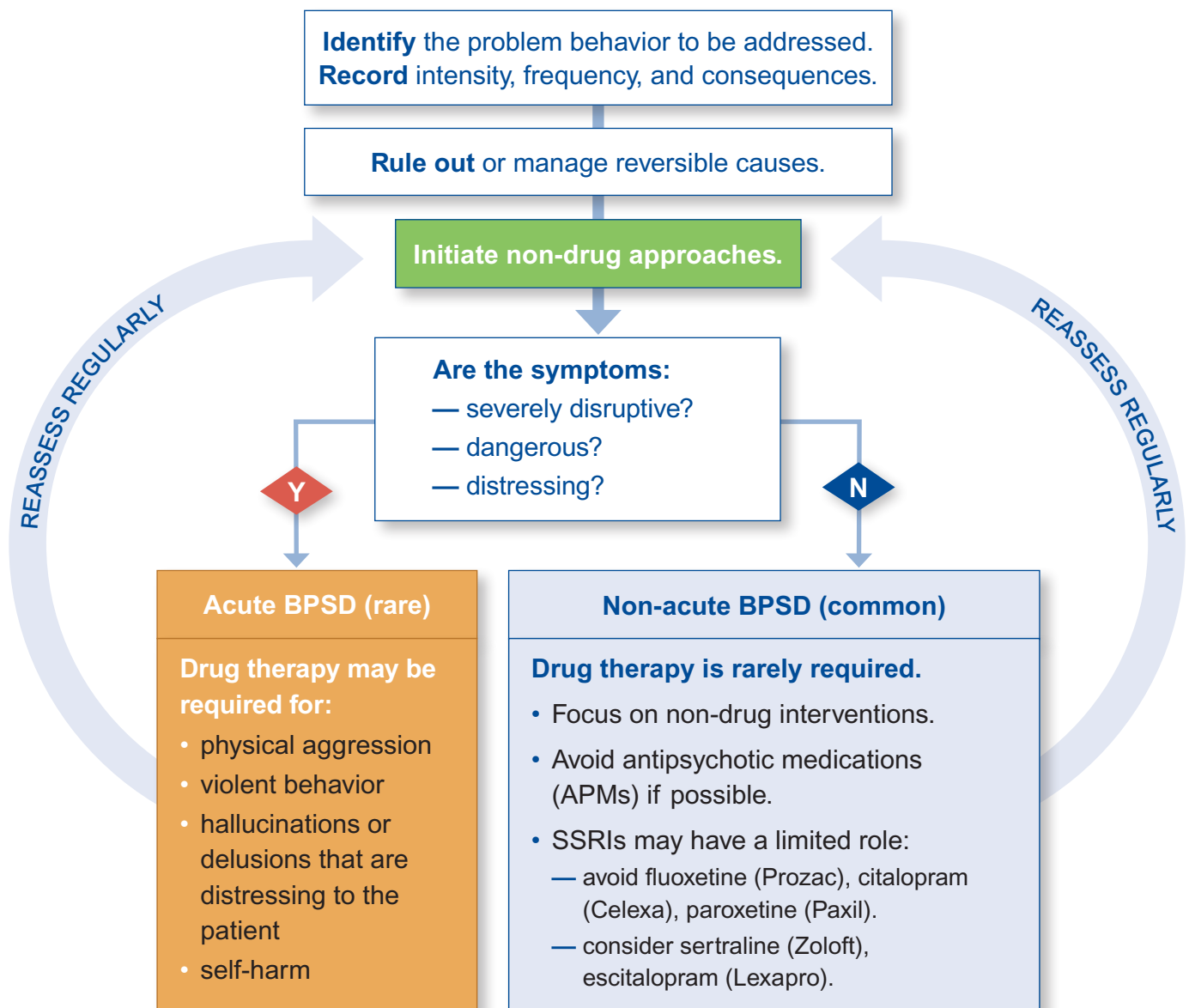
- Only fragmentary memory; substantial language, attention, and visual/spatial impairments; minimal or no capacity for self-care; frequent incontinence
- 24-hour supervision required. Decision is frequently between extensive home services and a dementia care unit.
- Reinforce the goals of care as previously established by the patient, usually a focus on patient comfort rather than on prolonging life.
- Consider discontinuing cognition-enhancing agents unless they have demonstrated a behavioral/psychiatric benefit.
- Use non-pharmacological strategies for managing behavioral and psychological symptoms.
- Consider hospice care when ambulation or eating are impaired.
- Home services, a day program, or respite care may be required.
- Involve a social worker with expertise in dementia or geriatric care issues.

3. The Alzheimer’s Association can provide counseling, support groups, and caregiver liaisons at all stages of MCI and dementia: [alz.org](https://www.alz.org).

Behavioral and psychological symptoms of dementia (BPSD) are common

Distinguish between acute and non-acute presentation. Acute BPSD includes symptoms such as aggression or delusions that are severely disruptive, dangerous, or distressing to the patient.

FIGURE 6. Managing behavioral problems in older patients with cognitive impairment^{15,16}



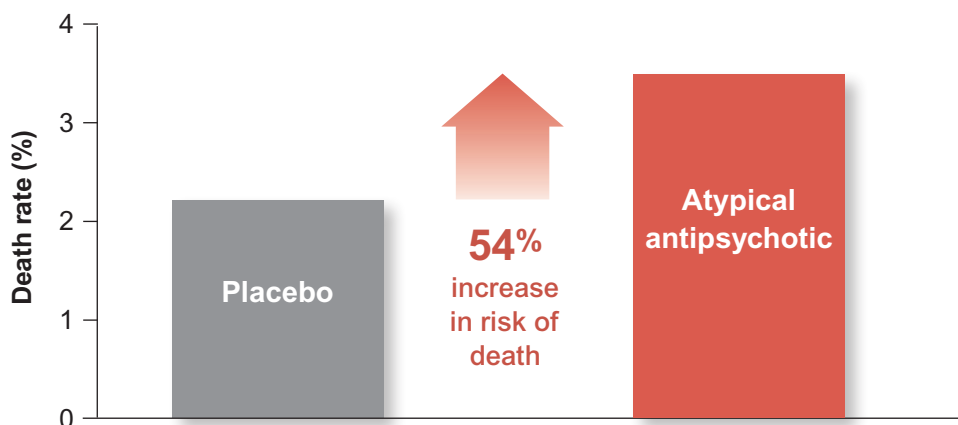
Limited use of antipsychotic medications (APMs) may sometimes be necessary to manage acute BPSD, but is seldom required for non-acute BPSD.

Avoid resorting to routine use of APMs to manage these symptoms of non-acute BPSD:

- insomnia
- wandering
- restlessness
- social isolation
- mild anxiety, nervousness
- inattention or indifference
- fidgeting
- uncooperativeness
- shouting

Randomized trials have shown that for every 100 patients with dementia treated with an atypical APM for 10-12 weeks, 1 will die due to a drug-related side effect.¹⁷

FIGURE 7. In a meta-analysis of 15 randomized trials, patients given an atypical APM were significantly more likely to die than patients given placebo.¹⁷



Data from clinical trials of aripiprazole, olanzapine, quetiapine, and risperidone.¹⁷ Other studies, which led to the FDA black box warning for all APMs, found a 60-70% increased risk of death.¹⁸

If an APM must be used to temporarily target a specific behavior that does not respond to non-drug approaches, do so cautiously:¹⁶

1. Identify and document the behavior being targeted.
2. Start the drug on a trial basis of limited duration, generally under 7 days.
3. Start at the lowest dose. Monitor for side effects.
4. Evaluate the efficacy of the drug on targeted behaviors.
5. Stop the drug after the trial period, and re-assess the patient.

Caregiver support resources

83% of people with dementia are cared for at home by family, friends, or other unpaid caregivers.¹⁹

Almost **60%** of caregivers report that the emotional stress of caregiving is high or very high.¹⁹

Situational and emotional coping classes can reduce anger, depression, and self-efficacy in caregivers, while increasing positive coping skills.²⁰

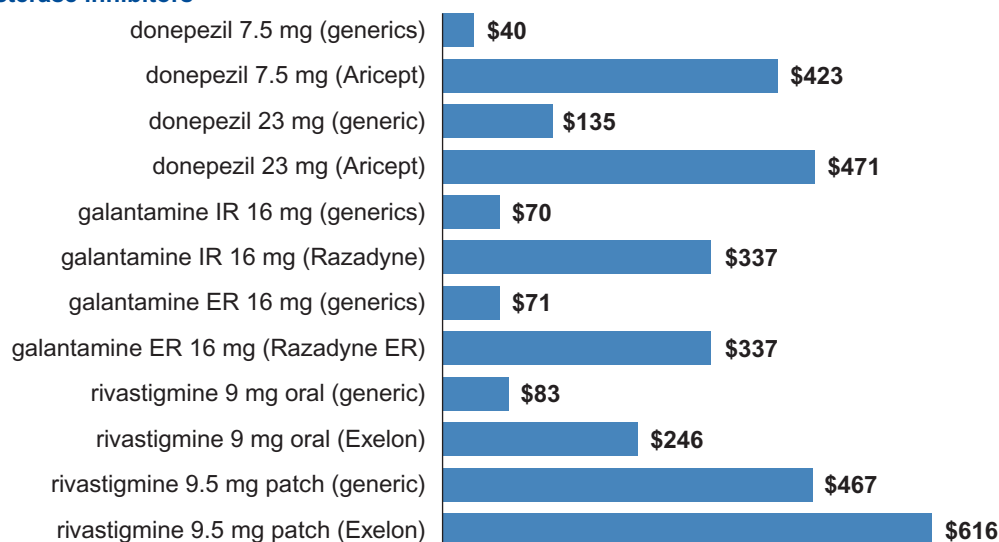
For links to area caregiver resources and support groups:

- Visit the *Caregiver Center* at alz.org
- Contact your local Area Agency on Aging: aging.pa.gov/local-resources/Pages/AAA.aspx

Costs of dementia medications

FIGURE 8. Price for a 30-day supply

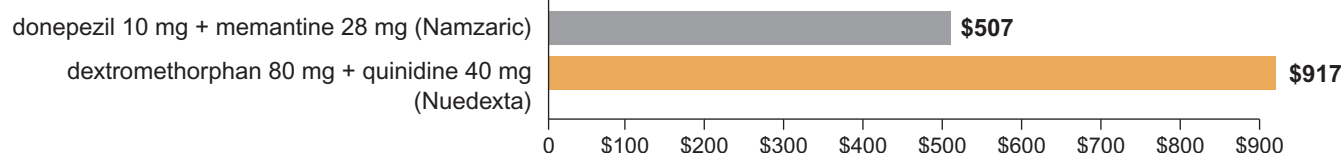
Cholinesterase inhibitors



NMDA receptor antagonist



combinations



Prices from goodrx.com based on World Health Organization Defined Daily Dose (WHO DDD). Accessed February 2017.

Key messages

Addressing elder abuse

- This problem is common, under-reported, and dangerous.
- Evaluating a patient's vulnerability to abuse can predict risk and lead to intervention.
- People with dementia are at increased risk of abuse.

Dealing with dementia

- Manage patients with cognitive impairment by looking for and addressing any reversible causes, optimizing general health, and addressing the consequences of cognitive impairment.
- Cholinesterase inhibitors and memantine, alone or in combination, can provide cognitive and functional benefits in some patients, but these benefits are usually modest and often transient.
- In managing behavioral and psychological symptoms of dementia (BPSD), use non-drug interventions in all patients and provide support to caregivers.
- Pharmacologic treatment of BPSD includes antipsychotic medications only for specific, identified dangerous behaviors, and may include antidepressants in patients with non-acute BPSD symptoms. If an antipsychotic medication must be used, do so cautiously and reassess often.

Visit AlosaHealth.org/ElderAbuse
for more resources and a detailed evidence document

References:

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- (2) Lachs MSB, J. *Under the radar: New York state elder abuse prevalence study*. New York, NY: Lifespan of Greater Rochester, Inc.; Weill Cornell Medical Center of Cornell University; and New York City Department for the Aging.;2011. (3) Lachs MS, Williams CS, O'Brien S, Pillemer KA, Charlson ME. The mortality of elder mistreatment. *JAMA*. 1998;280(5):428-432. (4) Schofield MJ, Powers JR, Loxton D. Mortality and disability outcomes of self-reported elder abuse: a 12-year prospective investigation. *J Am Geriatr Soc*. 2013;61(5):679-685. (5) Dong X, Simon MA. Association between elder abuse and use of ED: findings from the Chicago Health and Aging Project. *Am J Emerg Med*. 2013;31(4):693-698. (6) Dong X, Simon MA. Elder self-neglect is associated with an increased rate of 30-day hospital readmission: findings from the Chicago Health and Aging Project. *Gerontology*. 2015;61(1):41-50. (7) Dong X, Simon MA. Association between reported elder abuse and rates of admission to skilled nursing facilities: findings from a longitudinal population-based cohort study. *Gerontology*. 2013;59(5):464-472. (8) Lachs MS, Williams CS, O'Brien S, Pillemer KA. Adult protective service use and nursing home placement. *Gerontologist*. 2002;42(6):734-739. (9) Wigglesworth A, Mosqueda L, Mulnard R, Liao S, Gibbs L, Fitzgerald W. Screening for abuse and neglect of people with dementia. *J Am Geriatr Soc*. 2010;58(3):493-500. (10) Dong X, Simon MA. Vulnerability risk index profile for elder abuse in a community-dwelling. *J Am Geriatr Soc*. 2014;62(1):10-15. (11) Dong X. Screening for Elder Abuse in Healthcare Settings: Why Should We Care, and Is It a Missed Quality Indicator? *J Am Geriatr Soc*. 2015;63(8):1686-1688. (12) Moyer VA. Screening for Cognitive Impairment in Older Adults: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med*. 2014. (13) Courtney C, Farrell D, Gray R, et al. Long-term donepezil treatment in 565 patients with Alzheimer's disease (AD2000): randomised double-blind trial. *Lancet*. 2004;363(9427):2105-2115. (14) Howard R, McShane R, Lindesay J, et al. Donepezil and memantine for moderate-to-severe Alzheimer's disease. *N Engl J Med*. 2012;366(10):893-903. (15) Kapusta P RL, Bareham J, Jensen B. Behavior management in dementia. *Can Fam Physician*. 2011;57(12):1420-1422. (16) Croucher M. *The use of antipsychotics in residential aged care: clinical recommendations developed by the RANZCP faculty of psychiatry of old age (New Zealand)*. The Royal Australian and New Zealand College of Psychiatrists;2008 (reviewed 2011). (17) Schneider LS, Dagerman KS, Insel P. Risk of death with atypical antipsychotic drug treatment for dementia: meta-analysis of randomized placebo-controlled trials. *JAMA*. 2005;294(15):1934-1943. (18) Public Health Advisory: Deaths with Antipsychotics in Elderly Patients with Behavioral Disturbances [press release]. 2005. (19) Alzheimer's Association. *2016 Alzheimer's Disease Facts and Figures*. 2016. (20) Coon DW, Thompson L, Steffen A, Sorocco K, Gallagher-Thompson D. Anger and Depression Management: Psychoeducational Skill Training Interventions for Women Caregivers of a Relative With Dementia. *The Gerontologist*. 2003;43(5):678-689.

About this publication

These are general recommendations only; specific clinical decisions should be made by the treating physician based on an individual patient's clinical condition. More detailed information on this topic is provided in a longer evidence document at AlosaHealth.org.



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