



Dementia Management in the Outpatient Care Setting

By Jason Greenhagen DO

LMU

DeBusk College of Osteopathic Medicine
LINCOLN MEMORIAL UNIVERSITY

Disclosures

- No commercial interests to disclose
- Will be discussing the off-label use of medications

Objectives

1. Increase awareness of dementia in the outpatient care setting.
2. Be able to recognize and implement steps to diagnose dementia.
3. Utilize evidence-based treatment for dementia with and without behavioral disturbances.

Dementia Defined

- Dementia is a general term for a decline in mental ability severe enough to interfere with daily life.

- Alzheimer's Association

Dementia is Pervasive

- Dementia affects more than 5 million Americans of all ages
- ~13% of Americans age 65 years and older have dementia
- The prevalence of MCI in 65 years and older is ~16%
- Almost 1 of every 3 patients 65 years and older seen in primary care have some degree of cognitive impairment

Dementia is Complex

- Outpatient Care plays a key role as the first line of assessment and treatment of patients
- Two-thirds of all dementia is missed in the primary care setting
- ~91% of mild cognitive impairment is missed in the primary care setting

Why is it being missed?

- Time constraints
- Lack of knowledge or skill set
- Fear of making an incorrect diagnosis
- Inadequate reimbursement
- Difficulty with coordination between physicians and community services

Memory Assessment

Diagnostic Evaluation

- Cognition-focused history and examination
- Functional assessment
- Medication review for high-risk medications
- Evaluation for neuropsychiatric and behavioral symptoms

Assessment and Plan

- Evaluation of safety
- Identification of caregiver and needs
- Review of an advance care plan
- Staging of dementia

Cognition-Focused History and Examination

- Pt/Caregiver present providing information at visit
- Cognitively focused history
 - Memory concerns and initial onset of symptoms
 - Falls, head Injuries, strokes, seizures
- Behavioral/Psychological Symptoms
 - Depression (SIGECAPS), anxiety, mania, hallucinations, or delusions

Cognition-Focused History and Examination

- Past Medical Hx
- Past Surgical Hx
- Past Psych Hx

- Family Hx – Any hx of dementia, especially onset before age 65

- Social Hx – Ask about current and hx of substance use

Cognition-Focused History and Examination

- Review of Systems
- Physical Examination/Mental Status Examination
- Cognitive Screening
 - Mini-Cog
 - Mini-Mental State Evaluation (MMSE)
 - Montreal Cognitive Assessment (MoCA)

Functional Assessment

- Standardized measurements
 - ADL's – Katz
 - IADL's – Lawton-Brody

Staging of Dementia

- Functional Assessment Staging Test (FAST) Scale
 - Most well validated measure of the course of AD in the published, scientific literature
 - Utilizes IADL's and ADL's to stage the disease

Medication Review for High-Risk Medications

- American Geriatrics Society 2019 Updated AGS Beers Criteria
- Primary Targets
 - Anticholinergics
 - Antipsychotics
 - Benzodiazepines
 - Opioids

Evaluation for Neuropsychiatric and Behavioral Symptoms

- Patient Health Questionnaire (PHQ-2 → PHQ-9)
- Neuropsychiatric Inventory – Questionnaire (NPI-Q)

Evaluation of Safety

- Living Arrangements
- Driving
- Finances
- Medications

Caregiver and Needs

- Identification of caregiver(s)
- Understanding/knowledge
- Needs and social support
- Willingness/burden – caregiver burden scale

Review of an Advance Care Plan

- Two Main Elements
 - Durable Power Of Attorney (DPOA) – Limited (ex - health care, financial, etc.) or general
 - Living Will - a written statement of a person's health care and medical wishes if incapacitated
 - Ex – DNR, POLST, organ donation
 - Five Wishes – Only \$5

Quick Note on Reimbursement

- Cognitive Assessment and Care Planning Services (99483)
 - Medicare reimbursement for services aimed at improving detection, diagnosis, and care planning for patients with dementia

Cognitive Assessment and Care Planning Services (99483)

- Cognition-focused history and examination
- Functional assessment
- Medication review for high-risk medications
- Evaluation of safety
- Evaluation for neuropsychiatric and behavioral symptoms
- Identification of caregiver and needs
- Review of an Advance Care Plan
- Staging of dementia
- Medical decision making of moderate or high complexity
- Creation of a written care plan

Last Two Requirements

- Medical decision making of moderate or high complexity
 - as defined by Evaluation and Management (E/M) guidelines
- Creation of a Written Care Plan
 1. Specific cognitive disorder diagnosis
 2. Management of neuropsychiatric symptoms if present
 3. Comorbid medical conditions
 4. Safety management
 5. Caregiver stress and support

Cognitive Assessment and Care Planning Services (99483)

- Initial Psychiatric Evaluation 90792 = ~\$150
- New Outpatient Visit 99204 = ~\$167
- Annual Wellness Visit G0438 = ~\$172
- Cognitive Assessment 99483 = ~\$241 (3.44 RVU's)

Who Can Use 99483?

Eligible providers include:

- Physicians (MD and DO)
 - Nurse practitioners
 - Clinical nurse specialists
 - Physician assistants
-
- Can be used every 180 days; recommend 50 minutes
 - Note – Cannot be used with 99201 – 99215 on the same day

Questions?



What's Next?



What's Next?

- Further Testing Required?
 - Labs - CBC, BMP, LFT's, TSH, RPR, B12, Folate, and UDS
 - Imaging - MRI
 - Neuropsychological Testing

Treatment

- Treat underlying medical comorbidities and any reversible causes of dementia
- Socialization and Physical Activity
- Non-pharmacologic Interventions

Non-Pharmacologic Interventions

- Environmental modifications, assistive devices, and task simplification; PT/OT
- Social Services for education, support, and resources
- Sensory practices - aromatherapy, massage, multi-sensory stimulation, bright light therapy
- Psychosocial practices - validation therapy, reminiscence therapy, music therapy, pet therapy, meaningful activities

Caregiver Support

- Local Social Services Department
- Alzheimer's Association
 - www.alz.org
- Family Caregiver Alliance
 - www.caregiver.org
- Alzheimer's Disease Education and Referral Center
 - www.alzheimers.org/adear

Safety Concerns

- Driving Evaluations
- Level of Supervision
- Elder Abuse or Neglect

Pharmacologic Treatment



Pharmacologic Treatment

- 1st – Non-Pharmacologic Interventions!!!



Pharmacologic Treatment

- **1st – NON-PHARMACOLOGIC INTERVENTIONS!!!**



Dementia Specific Medications

- **Donepezil (Aricept)** – Mild to Severe dementia
 - Start 5 mg qhs, then increase in 4-6 wks to 10 mg qhs
- **Rivastigmine (Exelon)** – Mild to Moderate dementia
 - Start 4.6 mg patch daily, then increase every 4 wks up to max of 13.3 mg daily
- **Galantamine (Razadyne)** – Mild to Moderate dementia
 - Start 4 mg BID, increase by 4 mg every 4 wks to a max of 24 mg/day

Dementia Specific Medications

- **Memantine (Namenda)** – Mod to severe dementia
 - Start 5 mg daily, then increase in increments of 5 mg up to 10 mg BID
- **Memantine/donepezil (Namzaric)** – Mod to severe dementia
 - 4 wk starter pack (7 mg ER/10 mg IR), max 28 mg ER/10 mg IR q hs

Dementia Specific Medications

- Target – To maintain function as long as possible
- Behavioral effects – small, but statistically significant efficacy
- Discontinuation
 - No benefit seen during treatment
 - Significant decline in cognition/function over 6 months
 - Severity of dementia with little function to preserve

Antidepressants

- **Sertraline (Zoloft), Citalopram (Celexa), and Escitalopram (Lexapro)** were associated with a reduction in symptoms of agitation
- Citalopram vs Risperidone
 - Agitation symptoms and psychotic symptoms decreased and did not differ significantly
 - Risperidone had significantly increased side effects
- Citalopram now includes a black box warning with doses over 20 mg daily in people over 60 yo for QTc prolongation

Sleep Aids

- **Melatonin** – can be helpful in circadian rhythm disturbances; little evidence for long term sleep maintenance or doses >3 mg
- **Trazodone (Desyrel)** – can be helpful for sundowning and agitation and is more tolerated compared to antipsychotics (25-200 mg q hs)
- **Mirtazapine (Remeron)** – helpful for sleep, appetite, and mood
 - Lower doses = sleep and appetite (7.5 mg-15 mg q hs)
 - Higher doses = anti-depressant (30-45 mg q hs)
- **Suvorexant (Belsomra)** – safe and effective for primary insomnia in patients with dementia; expensive (5-20 mg q hs)
- **Doxepin (Silenor)** – H1 antagonist without anticholinergic effects (3-6 mg q hs)

Benzodiazepines and “Z-drugs”

- Benzodiazepines are not part of the recommended management of neuropsychiatric symptoms and should be avoided, especially for long-term management.
- Benzodiazepines carry significant risk of oversedation, delirium, and disinhibition, and may worsen behaviors that caregivers are trying to prevent.
- Benzodiazepines are associated with deterioration of cognitive functions, sedation, paradoxical disinhibition, risk of falls, and fracture of the femoral neck.

Anticonvulsants

- Evidence varies significantly and risk of oversedation and falls is increased
- No current anticonvulsant is recommended

Antipsychotics

- If possible, recommend referral to a geriatric psychiatrist.
- Only time these should be considered:
 - Hallucinations
 - Delusions
 - Physical Aggression

Antipsychotics Cont.

- **No significant evidence of typical antipsychotic efficacy and high risk of adverse events vs atypical antipsychotics**
- **Only modest evidence of atypical antipsychotic efficacy**
 - Risperidone (Risperdal), Olanzapine (Zyprexa), Quetiapine (Seroquel), and now Brexpiprazole (Rexulti)
 - Black box warning for “Increased mortality in elderly patients with dementia-related psychosis”
 - Rate of death = 4.5% (antipsychotic) vs 2.6% (Placebo)

Antipsychotics

- Brexpiprazole (Rexulti) is the only antipsychotic approved for **agitation** in dementia due to Alzheimer's disease
- Approved using two, 12-week, randomized, double-blind, placebo-controlled, fixed-dose studies
 - First study - 1 or 2 mg
 - Second study - 2 or 3 mg
- Patients who received 2 or 3 mg showed statistically significant reductions in Cohen-Mansfield Agitation Inventory scores

Brexpiprazole(Rexulti) Dosing

- Start 0.5 mg daily x7 days
- Increase to 1 mg daily x7 days, and then increase to 2 mg
- Recommended target dose is 2 mg once daily
- Maximum recommended daily dosage is 3 mg once daily after at least 14 days on the 2 mg dose

Brexpiprazole(Rexulti) Concerns

- **Maintains Black Box Warning** for increased risk of death in elderly patients with dementia related psychosis.
- Most common side effects - headache, dizziness, urinary tract infection, nasopharyngitis, and sleep disturbances (both somnolence and insomnia)
- **NOT** approved for the treatment of Alzheimer's patients with dementia-related psychosis without agitation

Brexpiprazole(Rexulti) Concerns

- Showed a maximum 5.3-point improvement over placebo on a 174-point scale, far short of the 17 points considered to be clinically important **(Only a 3% reduction)**
- “Brexpiprazole should absolutely not be assumed to treat all behavioral symptoms of dementia.” - Dr. Rajesh Tampi, M.D., M.S. and past president of AAGP
- Costs around \$1,400 a month so Otsuka and Lundbeck, are forecasting an additional \$1 billion in annual sales

Antipsychotics

- **Risperidone** – start 0.25 mg qhs; maximum of 1 mg daily
- **Olanzapine** – start 2.5 mg qhs; maximum of 10 mg daily
- **Seroquel** – start 25 mg qhs; maximum of 200 mg daily
 - NOT a primary sleep aid
- **Pimavanserin (Nuplazid)** – start 34 mg daily
 - Only approved for Parkinson's disease related psychosis

Conclusions

- Patients with cognitive impairment present often and screening for dementia should always be considered.
- Providers can be more adequately compensated using the 99483 billing code for Cognitive assessment and Care planning services.
- Non-Pharmacologic interventions are first line, and if possible, a multidisciplinary approach is best.

References

1. American Medical Association, (2018). Current procedural terminology. *Cognitive Assessment and Care Planning Services: Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation*, www.alz.org/careplanning/downloads/cms-consensus.pdf.
2. Cummings, J., Cherry, D., Kohatsu, N., Kemp, B., Hewett, L., & Mittman, B., (2002). Guidelines for managing Alzheimer's Disease: Part I assessment. *American Family Physician*, 65(11), 2263-2272.
3. <https://www.fda.gov/news-events/press-announcements/fda-approves-first-drug-treat-agitation-symptoms-associated-dementia-due-alzheimers-disease>
4. How the FDA approved an antipsychotic that failed to show a meaningful benefit but raised the risk of death; Doi:10.1136/bmj.p1801
5. FDA Approves Rexulti for Agitation Associated With Dementia Due to Alzheimer's Disease; <https://doi.org/10.1176/appi.pn.2023.07.7.17>
6. Katz, I., Jeste, D., Mintzer, J., Clyde, C., Napolitano, J., Brecher, M., (1999). Comparison of Risperdone and placebo for psychosis and behavioral disturbances associated with dementia: A randomized, double-blind trial. *J Clin Psychiatry*, 60 (2), 107-115.
7. Masopust, J., Protopopová, D., Vališ, M., Pavelek, Z., Klímová, B., (2018). Treatment of behavioral and psychological symptoms of dementias with psychopharmaceuticals: A review. *Neuropsychiatric Disease and Treatment*, 14, 1211–1220.
8. McCleery, J., Cohen, D., & Sharpley, A., (2016). Pharmacotherapies for sleep disturbances in dementia: Review. *Cochrane Database of Systematic Reviews*, 11, 1-67.
9. Moga, D., Roberts, M., & Jicha, G., (2017). Dementia for the primary care provider. *Prim Care Clin Office Pract*, 44, 439–456.
10. Parmar, J., Dobbs, B., McKay, R., Kirwan, C., Cooper, T., Marin, A., & Gupta, N., (2014). Diagnosis and management of dementia in primary care. *Canadian Family Physician*, 60:457-65.
11. Pollock, B., Mulsant, B., Rosen, J., Mazumdar, S., Blakesley, R., Houck, P., Huber, K., (2007). A double-blind comparison of citalopram and risperidone for the treatment of behavioral and psychotic symptoms associated with dementia. *The American Journal of Geriatric Psychiatry*, 15 (11), 942-952.

References

12. Reeve, E., Farrell, B., Thompson, W., Herrmann, N., Sketris, I., Magin, P., Chenoweth, L., Gorman, M., Quirke, L., Bethune, G., Forbes, F., Hilmer, S., (2018). Evidence-based clinical practice guideline for deprescribing cholinesterase inhibitors and memantine: Recommendations. *Sydney: The University of Sydney*. <http://sydney.edu.au/medicine/cdpc/resources/deprescribing-guidelines.php>.
13. Scales, K., Zimmerman, S., & Miller, S., (2018). Evidence-based nonpharmacological practices to address behavioral and psychological symptoms of dementia. *The Gerontologist*, Volume 58, S88–S102.
14. Schneider, L., Tariot, P., Dagerman, K., Davis, S., Hsiao, J., Ismail, S., Lebowitz, B., Lyketsos, C., Ryan, M, Stroup, S., Sultzer, D., Weintraub, D., and Lieberman, J. for the CATIE-AD Study Group, (2006). Effectiveness of atypical antipsychotic drugs in patients with Alzheimer’s Disease. *N Engl J Med*, 355, 1525-1538.
15. Sink, K., Holden, K., Yaffe, K., (2005). Pharmacological treatment of neuropsychiatric symptoms of dementia: A review of the evidence. *JAMA*, 293, 596-608.
16. Seitz, D., Adunuri, N., Gill, S., Gruneir, A., Herrmann, N., Rochon, P.,(2013). Antidepressants for agitation and psychosis in dementia: Review. *Cochrane Database of Systematic Reviews*, 2, 1-53.
17. Trinh, N., Hoblyn, J., Mohanty, S., & Yaffe, K., (2003). Efficacy of cholinesterase inhibitors in the treatment of neuropsychiatric symptoms and functional impairment in Alzheimer Disease: A meta-analysis. *JAMA*, 289(2):210-216.
18. clas.uiowa.edu/socialwork/sites/clas.uiowa.edu.socialwork/files/NursingHomeResource/documents/Katz%20ADL_LawtonIADL.pdf.
19. www.mccare.com/pdf/fast.pdf.
20. 2019 American Geriatrics Society Beers Criteria® Update Expert Panel (2019). American Geriatrics Society 2019 updated AGS Beers Criteria for potentially inappropriate medication use in older adults. *JAGS*, 00:1–21.

Questions???

