# Clinician's Guide to Telehealth for Older Adults: Dementia Care

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# Goals

| | |
|---|---|
| Share | Share a useful resource for clinicians |
| Show | Show you how to navigate this new resource |
| Case | Case based learning so immediately applicable |

# Learning Objectives

1. Be able to describe the sections and structure of the tele-dementia manual for older adults
2. Be able to locate the appropriate guidance from the manual when approaching the assessment of cognition in an older adult with cognitive concerns

3. Be able to locate the appropriate guidance from the manual when approaching the management of dementia behaviors

# Overview

- Getting started
- Tele-assessment of cognition
- Tele-management of dementia

| *Item* | *Page* | *When to use* | *Who can perform task* |
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| Pre-screening considerations | 5 | All visits | Any staff |
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| History taking | 8 | Assessing cognition | Physician, nurse, social worker, psychologist |
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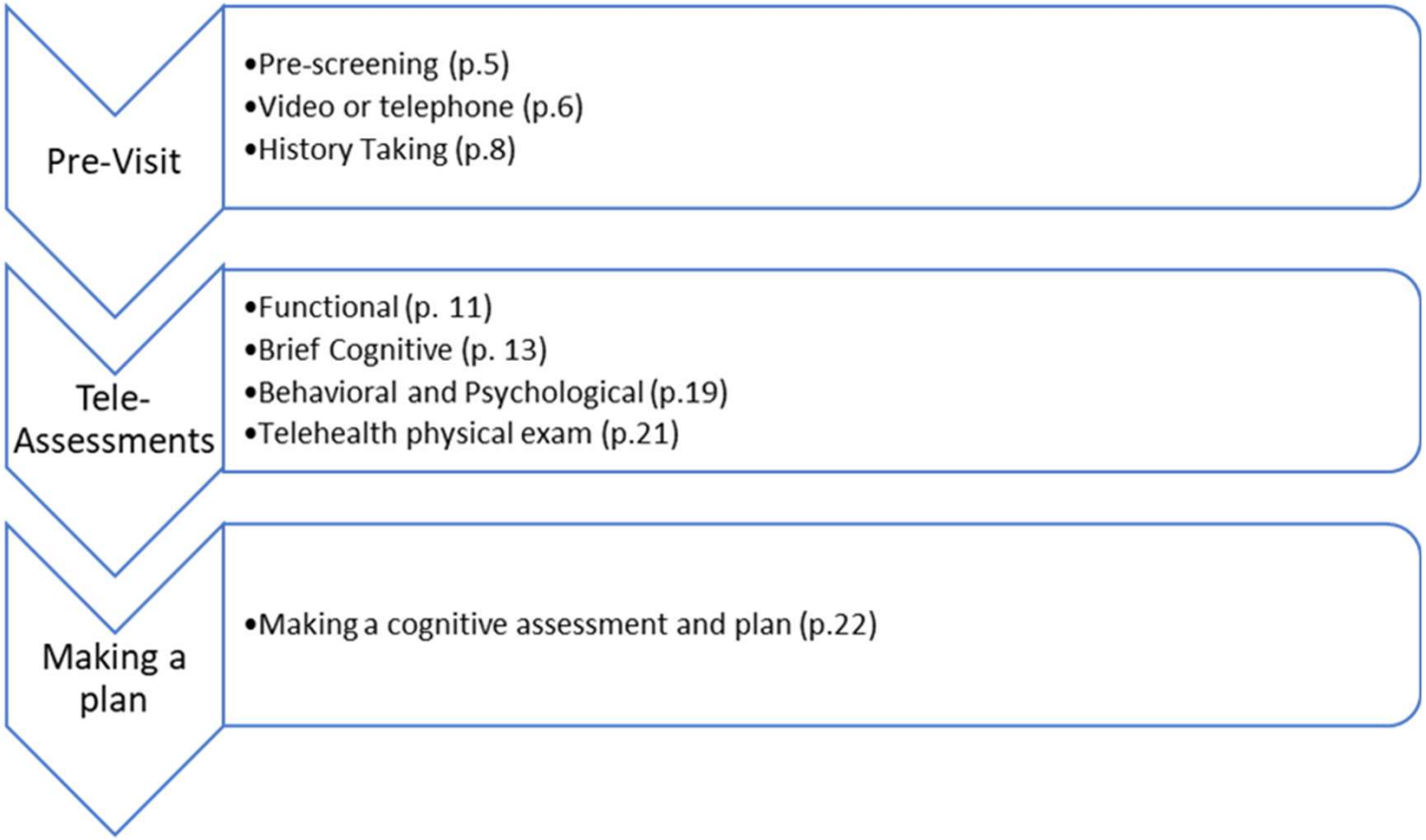
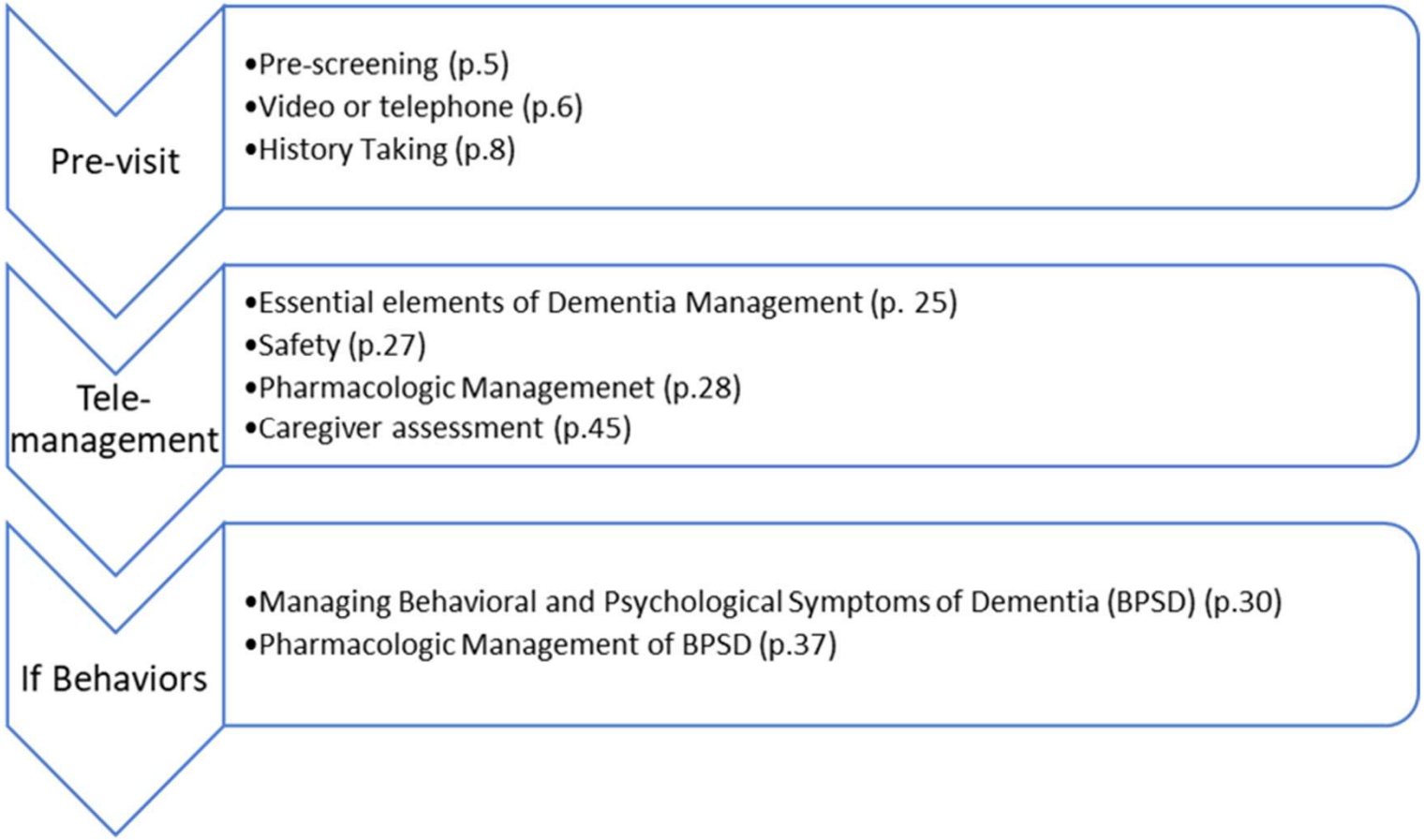
| Part 6: Caregiver assessment | 55 | For person with known dementia | Social worker, psychologist, nurse, physician |

# If assessing cognition in an older adult:



# If managing dementia in an older adult:



# Setting the scene

- You are a new Geriatric Medicine Fellow.
- You get this voicemail

"Hi doctor, I was wondering if we could talk to you about my mom's memory. I'm worried about it. We live pretty far away from the medical center so can we meet on telephone or video?"

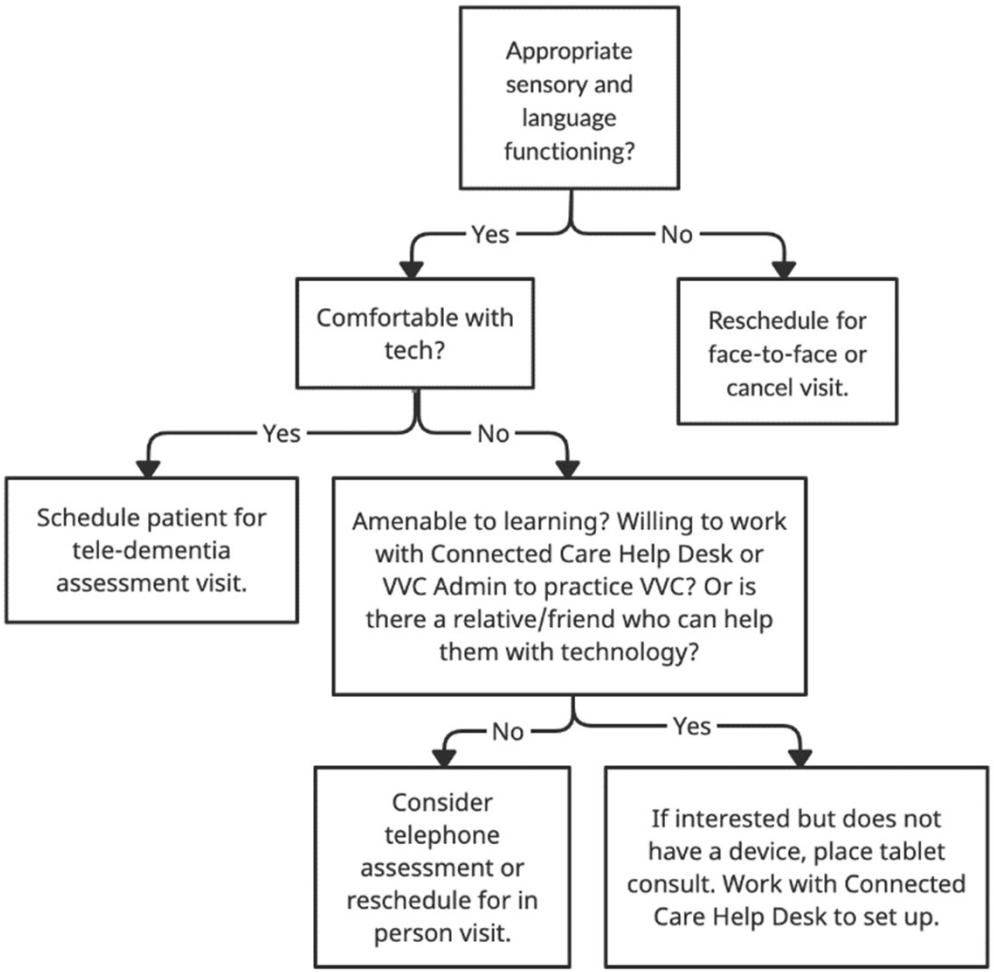
**Table of Contents:**

# Pre-screening Considerations

- To determine the feasibility and appropriateness for the tele-dementia visit, a team member will contact the patient via telephone to complete the following steps:

- **Step 1**: Screen for appropriate sensory and language functioning
- a. Screen for adequate hearing.
- b. Assess for adequate English proficiency.
- c. If intent is to schedule a video visit, ask about any vision issues with reading or seeing a screen.
- If no significant sensory or language limitations arise, then proceed to scheduling.

- **Step 2**: If video visit is appropriate, the examiner should explain the computer requirements of the visit and if the patient is comfortable with using a computer to complete this visit.


Appropriate sensory and language functioning?
Yes
No
Comfortable with tech?
Reschedule for face-to-face or cancel visit.
Yes
No
Schedule patient for tele-dementia assessment visit.
Amenable to learning? Willing to work with Connected Care Help Desk or VVC Admin to practice VVC? Or is there a relative/friend who can help them with technology?
No
Yes
Consider telephone assessment or reschedule for in person visit.
If interested but does not have a device, place tablet consult. Work with Connected Care Help Desk to set up.

# Case continued:

- You ask for your team nurse calls and screens the patient with these pre-screening considerations.

- You learn that the Veteran has mild hearing loss, but can adequately hear.
- Also you learn that the family has access to a tablet and internet and can conduct a video visit.
- Test call completed successfully

# *Case continued:*

*Ms. A is an 89 -year-old female Veteran presents for a video visit with worsening memory. She is accompanied by her son.*

*You know to ask about*

“How long has memory been worsening?”

“What else have you noted besides memory loss?”

*But you can’t recall how to comprehensively take a cognitive history….*

**Table of Contents:**

# History Taking 

***(Whenever possible, try to obtain the following history from an informant as well as the patient.)***
**Are there any dementia <u>warning signs</u> present?** Does the patient...

**Cognitive History:**
- How long have there been memory or other cognitive concerns?
- What type of cognitive concerns are present?
- Memory:
  - Short term versus long term memory impairment?
- Frontal executive:
  - Planning/organization Issues? (i.e. keeping track of future appointments, planning travel)
  - Able to multitask?
- Attention:
  - Trouble focusing on tasks? Easily distracted?
- Language:
  - Word finding difficulties?
  - Speech problems?
  - Expression and comprehension issues?
- Visual-spatial:
  - Navigation issues?
  - Getting lost in familiar places?

# Additional important history and chart review:

- Motor change
- Sleep
- Mood changes
- Hallucinations
- Behavioral changes

**Pertinent history/Review of Systems**

- Difficulties with hearing?
- Difficulties with vision?
- Pain?
- Urinary Incontinence?
- Weight loss? Or forgetting to eat meals?
- Other Review of Systems per usual care

**Past Medical History**
**Past Psychiatric History: depression, PTSD?**
**Head trauma?**

**Family History:**

- Family history of dementia? (Formal or suspected, type if known, age at onset)

**Social History:**
- Home living situation and support system (family, friends)?
- Any notable childhood trauma?
- Any known cognitive delay in childhood or ADHD?
- Education?
- Work history?
- Military history (Including job in military)?
- Alcohol and/or illicit substance use (past or present)?
- Any safety issues related to hobbies, work, or home life?
- Driving issues/accidents?
- Financial mismanagement? Subject of scams?
- With whom can medical information be shared?
- Power of attorney for healthcare? For finances?

**Allergies:** Per usual care.

**Medication Reconciliation:** (Review prescribed **and** over the counter)

**Chart review:**

**Current Labs**: (including CBC, BMP, Calcium, B12, TSH, LFTs, +/- HIV, +/- syphilis)

**Imaging:** Review any neuroimaging if present.

# Case continued:

*You learn that Veteran's short-term memory has been worsening for the past year and a half. She has gotten lost in her own neighborhood for several hours. Son is worried about her safety.*

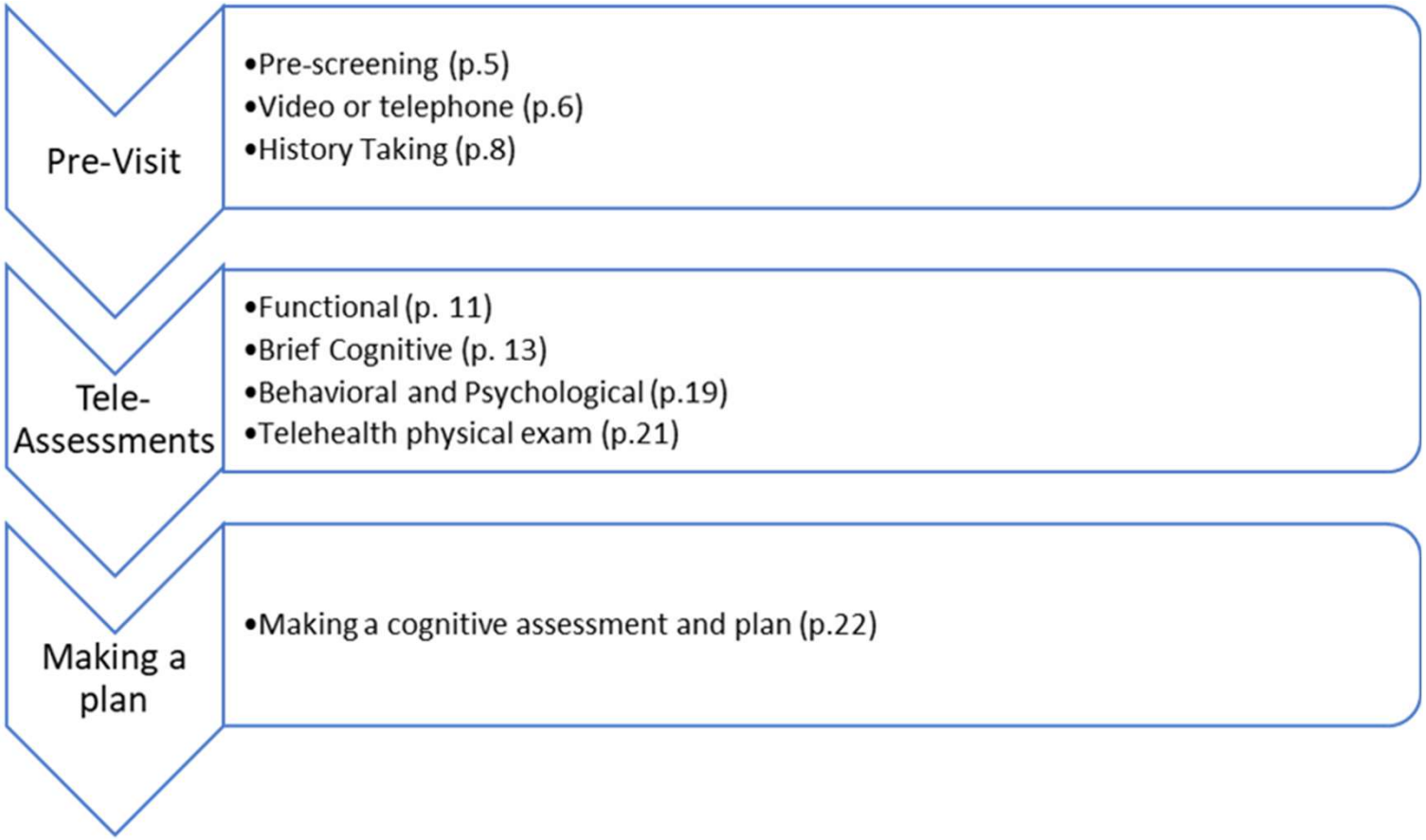
*The patient, on the other hand, has not noticed any significant changes in her memory. She denies depressed mood. Sleep is fine. No new physical symptoms reported.*

*PMH: age-related macular degeneration, osteoporosis, low back pain, arthritis, knee replacement, and gait and balance issues needing a cane.*
*No past psych history. No TBI.*

*Social history: widowed, Clerical work in military, then was homemaker raising children. Lives with son. They live 1.5 hours from the medical center. Daughter lives across the country.*
*Education: 12th grade education*

*Family history: parents died age 50s and 60s in a car accident. 2 siblings, 1 died of lung CA in 80s and other is living and has late onset Alzheimers, age 90.*

# If assessing cognition in an older adult:



# Functional Assessment

*(I= Independent, A=Assistance, D=Dependent)*

- *If there is impairment with either ADLs or IADLs, make sure to ask* ***whether this is a change in function from baseline capability***.
- *Similarly, make sure to inquire about the nature of the impairment.* ***Is it related to declining cognitive function, limitations in mobility or physical capabilities, or something else?***

| **Instrumental Activities of Daily Living** (IADLs) | (I, A, D) |
|---|---|
| Medication Management (Includes taking meds as prescribed/refilling meds) | |
| Appointment Management | |
| Finances (Who manages? Autopay use? Late payment/fees?) | |
| Meal Preparation | |
| Shopping | |
| Driving/Transportation | |
| Housekeeping | |
| Telephone use | |
| Technology Use (Email/internet, other than phone) | |

# Additional prompts

- *If uncertainty about any of the above, ask more questions, such as:*
  - **Medication Management**: Has the patient taken too little or too much medication? What is your organizational system for medications? Who orders refills? How do you order medication refills?
  - **Calendar and Appointments**: Who organizes and keeps track of appointments? Do you use calendars or organization tools? Has it always been done this way?
  - **Finances**: Have there been any missed or over payments? Are bills scheduled through autopay? Who oversees bank accounts and other financial assets?

# Case continued:

*She is dependent in all IADLs.*

*Son says she forgets to pay her bills, frequently misses her medical appointments*

*ADLs: Her personal hygiene has declined, and son has to encourage Veteran to bathe twice a week, or she avoids bathing.*

# Back to the manual table of contents

| | | | |
|---|---|---|---|
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# Case continued:

*No apparent delirium, and no fluctuations of cognition reported in history taking.*
*Geriatric depression scale negative, and no endorsemenet from son or Veteran about depressive symptoms*

*What could you do next? You can't remember which kinds of tests can be done on video, and which need to be done on phone.*

**Table 1. Telephone options of brief cognitive assessment:**

| *Test* | *Administration time* | *Number of items* | *Scoring* | *Notes* |
|---|---|---|---|---|
| *AD8* | *3 min* | *8* | *8 points (0-1 normal cognition, 2 or greater cognitive impairment is likely)* | *Administered to informant, not person with dementia. See test form in appendix* |
| *Short portable Mental Status Questionnaire* | *5 min* | *10* | *10 points (3-4 errors mild cognitive impairment, 5-7 errors mod cog impairment, 8+ severe cog impairment)* | *See test form in appendix* |
| *Blessed* | *3-5 min* | *6* | *28 points (weighted* | *See test form in* |

**Video options of brief cognitive assessment**:

- Check to see if any brief cognitive assessments were conducted in the past, either in-person or over video (e.g., SLUMS, MOCA, MMSE). It is helpful to conduct

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Video options for brief cognitive assessment

| Test | Administration time | Number of items | Scoring | Notes |
|---|---|---|---|---|
| AD8 | 3 min | 8 | 8 points (0-1 normal cognition, 2 or greater cognitive impairment is likely) | Can be administered to an informant. See test form in appendix |
| Short portable Mental Status Questionnaire | 5 min | 10 | 10 points (0-2 errors: normal mental functioning 3-4 errors: mild cognitive impairment 5-7 errors: moderate cognitive impairment 8 or more errors: severe cognitive impairment) | See test form in appendix |
| Mini-Cog | 3-5 min | 2 | 5 points (A total score of 3, 4, or 5 indicates lower likelihood of dementia but does not rule out some degree of cognitive impairment) | Has a clock draw component, patient will need a blank piece of paper and writing utensil<br><br>See test form in appendix |
| Blessed Orientation and Memory Concentration Test | 3-5 min | 6 | 29 points (weighted scores totaling greater than 10 are generally accepted as an indication of the presence of clinically meaningful cognitive impairment) | See test form in appendix |
| **SLUMS** | **10 min** | **11** | **30 points (High school education: 27-30 normal, 21-26 mild neurocognitive disorder, 1-20 dementia; Less than high school education: 25-30 normal, 20-24 mild neurocognitive disorder, 1-19 dementia)** | **Will need to screen share pictures. Has a clock draw component, patient will need a blank piece of paper and writing utensil.<br><br>See test form in appendix** |
| MOCA (use only if certification in place) | 10 min | 13 | 30 points (normal is ≥ 26) | Will need to screen share first two sections. Has a clock draw component, patient will need a blank piece of paper and writing utensil<br><br>Please download from website if you have completed the certification |
| General Practitioner Assessment of Cognition (GPCOG), 2002 | 5 minutes for patient, 5 minutes for informant | 4 patient items<br>6 informant items | Max Score=9 for patient exam and 6 for informant interview | The test form utilizes a non-US address that may be difficult for some patients. See test form in appendix |

***Please note that for any of these brief assessments, you must know how to administer them in person before att[illegible]g to administer them in a non-standard setting. If you do not feel comfortable, we recommend completing the AD8, a[illegible]rring to a specialist (neuropsychology, geriatrics, or neurology) if concerns emerge***

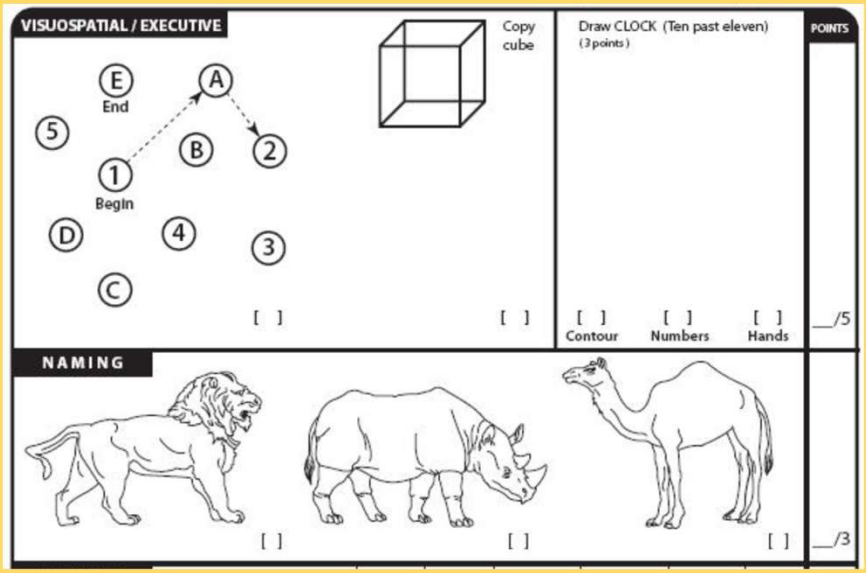
# Brief Cognitive Assessment

1. Based on interview, appears that Ensure the patient's hearing is adequate for this assessment. Ensure that volume is high, and that the patient has headphones if desired.
2. Ensure paper, pencil, and any relevant test materials are available (if sent ahead). Mailed test materials should not be opened until instructed to do so.
3. Confirm adequate audio and/or video connection quality. Make sure video visit window is maximized and chat is hidden from view. Remind patient to keep phone silenced.
4. Remind patient about the purpose and process of cognitive assessment and advise them to try their best.

***Telehealth tip: Ask the caregiver (if present) or patient to put away any calendars or clocks that may be present in their room prior to conducting the assessment.***

# Case continued:

- You proceed with the telehealth MOCA as you completed the certification and are familiar with the test form.
- You remember an attending showing you how to screenshare the screen clippings



# *Case continued:*

- *You try to administer a MOCA but it seems very frustrating to Veteran and she is concretely repeating your instructions. She also seems to be having a lot of difficulty seeing the figures despite wearing glasses.*

- *You go back to the manual to check out some of the telephone options that don't have a visual component*

# Case continued:

*You administer a Blessed Orientation and Memory Concentration (BOMC) Test and she scores 15/28, indicating cognitive impairment.*

# Next step?

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# Behavioral and Psychological Symptom Assessment
# Tele-physical exam

Psychiatric ROS negative

Notable findings on physical exam:
**General appearance:** Clothing with food stains, sitting up in chair
**Hearing** adequate for conversation
**Psych:** attitude cooperative and pleasant, mood good as observed, speech spontaneous and fluent, but minimal speech noted. Eye contact appropriate, denies auditory or visual hallucination, denies suicidal ideation, no evidence of paranoia or delusions, linear thought process

**Thought content:** Vague details, generally defers to son to answer questions

# Making a plan and putting it all together

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# Making a Cognitive Assessment and Plan:

- Review data so far obtained above from history taking, functional and cognitive assessment, focused Tele-physical exam and assessment of behavioral and psychological symptoms
- **Review medications**
- If the following **labs** were not ordered prior to your assessment, order CBC, BMP, Calcium, B12, TSH, LFTs, +/- HIV, +/-syphilis. Goal is to look for potentially reversible or treatable causes for dementia/cognitive decline.
    - **If B12<300, recommend repletion. If concern for increased pill burden, could confirm true B12 deficiency by checking MMA.** High MMA levels correspond to vitamin B12 deficiency.
- **Head imaging is recommended when considering a diagnosis of Mild Cognitive Impairment or any type of dementia. If head imaging has not been completed in the past year or so, consider ordering a non-contrast Brain MRI or Head CT (if unable to tolerate MRI)** unless the risks/stress of study exceed potential benefit gained. **Assess and address any untreated depression, anxiety, PTSD, or sleep disorder such as sleep apnea.**
- Ensure co-morbid medical illnesses are appropriately treated and monitored, including vascular risk factors (HTN, HLD, DM), pain conditions, etc.
- Assess and address vision issues, hearing issues, and any aids that could help level of functioning. Refer to eye clinics, audiology, and therapists as appropriate.
- Observe the surrounding environment during a video telehealth visit. Is it clean and non-cluttered? An unclean home environment may be a sign of self-neglect or caregiver stress/burden.
- **Recognize conditions that need timely action and referral:**
- Certain individuals could benefit from **in-person evaluation**.
- **If the older adult patient's clinical, cognitive and functional trajectory and presentation is consistent with a neurodegenerative process AND all reversible processes that could mimic a neurodegenerative process are considered and addressed (depression, delirium, medications causing confusion, altered thyroid levels/notable electrolyte discrepancies), you may make a working diagnosis of Mild neurocognitive disorder (AKA mild cognitive impairment) or Major neurocognitive disorder (AKA Dementia) based on DSM-5 Criteria (see below). Add further specifiers of etiology, severity and others when known. If you are not certain of the etiology, consider referral to a specialist for further diagnostic evaluation and clarification.**
-

# *Case continued:*

- **Medications:**
- Tylenol
- *Alendronate*
- *Diclofenac gel*
- *Lidocaine patch*

- B12 400
- TSH wnl
- Labs are unremarkable and a recent head CT shows generalized atrophy.

# Making a cognitive assessment and plan

Given congruence of clinical trajectory, functional decline, lack of other identified conditions influencing cognition, and score on the BOMC cognitive assessment, this 89 year old Veteran's clinical picture is consistent with dementia.  There is insufficient information on brief cognitive assessments to determine etiology.

# Overview

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- Tele-management of dementia

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# Setting the scene: Part 2

You get this voicemail

“Hi doctor, my dad is getting pretty agitated, and the caregivers say it’s sundowning. It’s really hard for me to transport him right now- can we meet somehow on telephone or video?”

*Case continued:*

Your patient Mr. B is an 82 yo M Veteran with moderate-severe Alzheimer's dementia, obesity, and diabetes, who gets agitated in the evenings. Son is calling for tele-dementia management assistance of these behavioral and psychological symptoms of dementia (BPSD)

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# Steps to Evaluate Behavioral and Psychological Symptoms of Dementia (BPSD)

1. Evaluate timeframe that the behaviors have been occurring, and whether there are any corresponding changes in the patient's life (e.g., new over the counter or prescription medication, changes to living situation, births/deaths, etc.) or obvious triggers for the behavior.
2. Rule out a component of delirium (consider underlying conditions)
3. Consider unmet needs that could be manifesting as difficult behaviors such as: Pain, Hunger, Thirst, Fatigue, Toileting needs, Boredom and Restlessness

**A-B-C Approach to Behavioral Problem Solving**

| **ANTECEDENT** - | **BEHAVIOR** - | **CONSEQUENCE** |
|---|---|---|
| (who, what, when, where) | (specific behavior trying to change) | (What happened after the behavior?) |

# Getting more details

*Pattern: gets agitated around 5pm each day*

*His caregiver tells you that he is "sundowning". He gets agitated, throws things, and becomes angry. When he does this, the caregiver tries to distract with food or TV, typically without success. The caregiver asks Mr. B to calm down. They end up yelling at each other and eventually the caregiver gives Mr. B space to calm down. The evenings are always distressing for both the Veteran and the caregiver.*

# Putting behaviors into the A-B-C framework

- ***Behavior:*** *Sundowning at 5pm every day*
- ***Consequence:*** *The caregiver first tries to stop the behavior using distraction. Then the caregiver asks Mr. Smith to calm down. Eventually the caregiver yells. Finally, the caregiver gives the patient space.*
- ***Antecedent:*** *Unclear at this time ("It just seems like he's sundowning.")*

- You also note timeframe of 6 weeks doesn't correlate with any other changes, and no new review of systems to suggest delirium from a secondary process

## *You ask more questions:*

- *Does Mr. B have pain? No, he has not mentioned pain.*
- *Has he ever had pain? "Yes, he had back and neck pain for decades and used to take opioids. However, after he developed dementia, he gradually stopped reporting the back pain. He is no longer on any medication for pain."*

- *Given that he has had chronic pain for decades, he likely still has some physical discomfort. It is worth exploring this as an antecedent for the behavior.*

## *To change this behavior, we can change the antecedent or change the consequence.*

- ***Opportunities for intervention:***
- ***Consider antecedents:*** *Try heating pads and medication like Tylenol (non-pharm and pharm together) to address the antecedent of chronic back and neck pain.*
- *Are there other antecedents that could be triggering the patient?* ***Is the environment chaotic? Is it loud?***
- ***Is there a different unmet need?*** *Could restlessness or boredom be contributing?*
- *The caregiver's frustrated yelling response could be further exacerbating this behavior.*

*Could change the consequence to, "Ok Mr. B, it looks like you need something. Let's try putting a heating pad on your back and listening to some nice music. I'll get you some water to drink."*

- ***Consider changing the consequence*** *by reacting differently to their behavior. Redirect by engaging the person with reminiscence.*

# Case continued:

- You prescribe Tylenol at 4 pm and heating pads to address the pain.
- Caregiver starts putting on soothing music at 4 pm automatically and prepares for evening in a different room, maintaining a calm environment for the Veteran
- Evening situation improves

# Case continued:

- **1 month later…**
- **You are called because the patient has recently moved to an residential care facility and is having new behaviors in evening**

Increasing agitation and paranoia in the late afternoons. His caregivers state that he often wanders around the facility calling out for his wife. He wanders into the rooms of neighboring residents and when he encounters another resident or staff member, he often shouts and becomes combative, accusing them of kidnapping his wife or stealing his things. Most recently, he hit and injured another resident during one of these episodes. The caregivers are understandably alarmed and are requesting pharmacologic assistance in managing his disruptive and sometimes harmful behavior. They are already optimizing non-pharmacologic management. No allergies. QTc is 450 on last EKG last year during a hospitalization.

| *Item* | *Page* | *When to use* | *Who can perform task* |
|---|---|---|---|
| Background and intended audience | 5 | All visits | n/a |
| Pre-screening considerations | 5 | All visits | Any staff |
| Deciding between a telephone visit and face-to-face visit | 6 | All visits | Clinical staff |
| Equipment and supplies | 7 | All visits | Any staff |
| Prior to starting a phone or video visit checklist | 7 | All visits | Any staff |
| History taking | 8 | Assessing cognition | Physician, nurse, social worker, psychologist |
| **Tele-Assessments** | | | |
| Functional assessment | 11 | All visits for known dementia | Physician, nurse, social work, psychologist |
| Brief Cognitive assessments | 13 | When assessing cognition | Physician, nurse, social worker, psychologist |
| Behavioral and Psychological Symptom assessment | 19 | For person with known dementia | Physician, nurse, social worker, psychologist |
| Telehealth physical exam | 21 | All visits | Physician |
| Making a cognitive assessment and plan | 22 | When assessing cognition | Physician or psychologist |
| **Tele-Management** | | | |
| Part 1: Essential elements of Dementia Management (using 4Ms framework) and explaining dementia stages to families | 25 | For person with known dementia | All clinical staff can do portions of 4Ms as consistent with their scope of practice. All staff can explain dementia stages and progression |
| Part 2: Resources for Safety Management | 27 | For person with known dementia | Clinical staff |
| Part 3: Pharmacologic Management of dementia | 28 | For person with known dementia | Physician, can work with a pharmacist |
| Part 4: Managing Behavioral and Psychological Symptoms of Dementia (BPSD)<br>• Case examples | 30<br>34 | For person with known dementia | Physician, nurse, social worker, psychologist |
| Part 5: Pharmacologic Management for BPSD<br>• Case examples | 37<br>43 | For person with known dementia | Physician, can work with a pharmacist |
| Part 6: Caregiver assessment | 55 | For person with known dementia | Social worker, psychologist, nurse, physician |

| | | | |
|---|---|---|---|
| Part 4: Managing Behavioral and Psychological Symptoms of Dementia (BPSD)<br>• Case examples | 25<br>27 | For person with known dementia | Physician, nurse, social worker, psychologist |
| Part 5: Pharmacologic Management for BPSD<br>• Case examples | 29<br>34 | For person with known dementia | Physician, can work with a pharmacist |

# Part 5: BPSD Pharmacologic Management:

**When to Consider Pharmacologic Treatment: If non-pharmacologic interventions have failed to sufficiently address BPSD, pharmacologic intervention may be considered.**

**General Approach to Medication Management:**

•Reduce anticholinergic medications as able—one study showed reducing these medication burdens by at least 20% significantly reduced severity and frequency of BPSD and reduced caregiver stress.[31]

•Identify the target symptoms and choose medication most closely related to this to avoid unnecessary antipsychotic use. For example, use antipsychotic for psychosis, SSRI for underlying anxiety or depression, or Tylenol for pain.

3. Follow geriatric principles of "start low, go slow" with SSRIs, especially if targeting anxiety symptoms. Some patients may initially experience exacerbated anxiety before symptoms improve if medications are titrated too quickly.

**Table 9. Possible medications to use to pharmacologically manage dementia behaviors**

| | | | |
|---|---|---|---|
| ol (and other n treatments) | No (treating unmet pain needs that could trigger BPSD) | Often larger doses like 1000mg are more effective for pain control. Do not exceed recommended daily max amounts. Consider other patches, creams, and heating pads for pain control as well. | There is evidence o efficacy of pain treatm reducing dementia behaviors[33, 34] |
| Citalopram, escitalopram, sertraline | No | For patients with high risk for QTC prolongation, ideally would check EKG within a week of starting citalopram or escitalopram. | Sertraline and citalopram were associated with modest improvement of psychosis and agitation compared with placebo[11, 12] |
| Other SSRIs (fluoxetine, vortioxetine) | No (if treating underlying depression) | Avoid paroxetine given anticholinergic properties. | ** |
| Non-SSRI Antidepressants (Mirtazapine, venlafaxine, uloxetine, roprion) | No (if treating underlying depression) | Avoid tricyclics and MAOIs<br><br>Be cautious with venlafaxine in non-compliant patients due to risks of | ** |

# Antipsychotic medications

Table 10. Second Generation Antipsychotic Options

| Medication | Starting dose | Typical Dosage Range | Indications | Side effect considerations |
|---|---|---|---|---|
| Risperidone | 0.25mg | 1-2mg/day* | Agitation, Psychosis, Aggression | Extrapyramidal effects, hyperprolactinemia |
| Olanzapine | 2.5 mg | 5- 10 mg/day | Agitation, Overall symptoms, +/- psychosis | Anticholinergic effects, sedation, metabolic effects, weight gain |
| Quetiapine | 25 mg | 100-150mg mg/day | | |
| Aripiprazole | 2.5 mg | 5 -10mg/day | | |

Table 11. **Second-Generation Antipsychotics by Indication:**

| Indication | Suggested Medication and Notes |
|---|---|
| Overall behavioral and psychologic symptoms | Aripiprazole has best evidence, but Olanzapine and Risperidone also show low utility. |
| Agitation | Risperidone has best evidence, but the other Second Generation Antipsychotics (SGAs) |

Table 12. **Monitoring Adults Taking Antipsychotic Medications**

| Symptom to Monitor | Schedule for Monitoring | Additional notes and how to monitor over telehealth |
|---|---|---|
| **Orthostatic hypotension** | BP at initiation, q3 months during titration, then annually | Clozapine, Olanzapine, Pimvanserin, Paliperidone, and Quetiapine highest risk.<br>Will need to inquire about symptoms of orthostatic hypotension. |

# Case continued

- *<u>Management options</u>: Since the psychotic symptoms present (delusions) are causing distress and resulting in behaviors that are unsafe to patient and others, antipsychotic treatment is reasonable to consider here if all other unmet needs are considered (I.e., pain, anxiety). You must discuss black box warning and risks/benefits with his power of attorney.*

- *Given metabolic syndrome, you consider risperidone, quetiapine, or aripiprazole over olanzapine given olanzapine's known side effect of weight gain. You start risperidone 0.25 mg once a day in the afternoon to help reduce the behaviors. You also reassure patient that his wife is okay and show pictures of them together that you find in his room. He tells you stories about his family.*

# Case continued

- *The next week you check in and he is still agitated, although caregivers feel that it is overall improved since starting the risperidone, but still stressful.  You increase risperidone to 0.5 mg daily.*

- *<u>Long term medication strategy</u>: Antipsychotics are off label use and not intended for long term use. Even if this treatment works, as soon as the patient's behavior stabilizes, one should attempt gradually weaning the antipsychotic if tolerated.*

# Part 6: Caregiver assessment

- Caregiver Interventions, Support, and Resources
- Questions about decisional capacity and conservatorship
- 
- Advance Care Planning
- 
- Hospice Criteria for dementia

# Appendix

## Additional Resources for caregivers:

Compiled list of dementia care resources in one place for caregivers from the VA Geriatrics Research, Education, and Clinical Centers
Gerischolars/Dementia Resources for Caregivers and Families

Dementia caregiver guide with easy-to-understand content
Dementia Caregiver Survival Guide (gerischolars.org)

Reliable dementia related health information from the National Institute on Aging Dementia | National Institute on Aging (nih.gov)

Caregiver video series and Veterans resources from the VA Office of Rural Health RESOURCES - Office of Rural Health (va.gov)

UCLA Caregiver training videos Caregiver Education | UCLA Alzheimer's and Dementia Care Program - Santa Moncia, CA (uclahealth.org)

VA Caregiver support program https://www.bing.com/search?q=uva caregiver support program&qs=n&form=QBRE&sp=-1&pq=uva caregiver support program&sc=8-29&sk=&cvid=E2A1DE6E6E914ED1AA775D3101AB7EAB

List of potentially inappropriate medications for older adults
American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults - - 2019 - Journal of the American Geriatrics Society - Wiley Online Library

**Additional VA resources to learn more about non-pharmacologic management**
**STAR-VA: Interdisciplinary Behavioral Care for CLC Residents with Dementia** STAR-VA and Dementia Training Resources (sharepoint.com)

Montessori Approaches in Person-Centered Care (MAP-VA): An Effectiveness-Implementation Trial in Community Living Centers Welcome to MAP-VA! (sharepoint.com);

**+ Tools mentioned in manual**
**+ ICD 10 codes up to date for dementias**

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# Where to find this manual

- Will soon be posted on the Gerischolars website
- Appreciate your help completing a survey monkey about this webinar and tool- we hope to bring you many more useful and practical tools for telehealth management of older adults with dementia