




Recap of Day 1




- 4Ms of an Age-Friendly Health System
- Attitudes about Aging
- Adult Development
- Common Life Issues and Practice Issues
- Grief and End of Life
- Substance Use

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Overview of Day 2

- Psychopharmacology
- Depression, Anxiety, and PTSD
- Suicide
- Serious Mental Illness
- Cognition
- Ethics
- 4Ms Complex Case Discussion


  

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Pharmacology
Be aware of side effects; reduce polypharmacy

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Normal Aging and Medications

- Pharmacokinetics: Absorption, distribution, metabolism, and elimination
 - Substances take longer to clear
 - Substances may build up
 - Kidneys shrink with age
 - Slower metabolism
- Pharmacodynamics: what drugs do to the body
 - Increased side effects
 - Increased drug interactions

E-CENTER **CATCH-ON** **RUSH**

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Polypharmacy

Common in older adults

- 36% are prescribed 5+ drugs
- 20% of drugs used may be inappropriate
- 42% of patients fail to inform providers about the use of complementary and alternative medications
- 40% of over-the-counter drugs purchased by older adults


POLYPHARMACY IS COMMON AND POSES RISK



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Anti-depressant and anti-anxiety medications

- Used to treat depression and anxiety disorders
- Serotonin Reuptake Inhibitors (SSRIs) most commonly prescribed
 - Generally safe for older adults
 - **Serotonin Syndrome**: rare, serious side effects
- Atypical Antidepressants
 - Mirtazapine & bupropion



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Safety Considerations

- When an older adult is starting an antidepressant, it is important for members of the treatment team to evaluate suicide risk

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CLINICAL INVESTIGATION

American Geriatrics Society 2019 Updated AGS Beers Criteria[®] for Potentially Inappropriate Medication Use in Older Adults




By the 2019 American Geriatrics Society Beers Criteria[®] Update Expert Panel[®]

- Antihistamines
- Antiparkinsonian Agents
- Skeletal Muscle Relaxants
- Antidepressants
- Antipsychotics
- Antiarrhythmics
- Antimuscarinics
- Antiemetic
- Opioids
- Benzodiazepines

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Side effects to watch for


- **Anticholinergic**
 - Blocks acetylcholine
 - Dry mouth (note ill-fitting dentures), confusion, falls, urinary retention, hallucinations, and delirium
- **Sleep medications**
 - Anticholinergic effects
 - Physical and psychological dependency, memory impairment, disinhibition, paradoxical agitation
 - Melatonin: vivid dreams or nightmares, drowsiness, dizziness, irritability, and stomach cramps
- **Tricyclic antidepressants**
 - Anticholinergic effects
 - Sedation, cardiac rhythm abnormalities, orthostatic hypotension, hypertension, tremor, decreased seizure threshold, agitation, and insomnia
- **Benzodiazepines**
 - Enhances GABA
 - Cognitive decline, fall risk
 - Sedation, falls, trauma, and delirium, when prescribed with opioids
 - Must taper under medical supervision

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Side effects to watch for: Cognitive enhancers

- Acetylcholinesterase inhibitors**
 - Enhance acetylcholine
 - Bradycardia
 - Weight loss
 - Nausea, diarrhea
 - Abnormal dreams, insomnia
 - Headache
- NMDA antagonists**
 - N-methyl-D-aspartate receptor antagonists
 - Dizziness
 - Headache
 - Constipation
 - Confusion
 - Bradycardia
- Monoclonal antibodies**
 - Break down amyloid beta plaques
aducanumab, lecanemab, donanemab
 - Edema
 - Microhemorrhage
 - Headache
 - Falls
 - Diarrhea



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Role of Non-Prescribing Team Member

- Help older adults reconcile and evaluate medications
- Assess adherence to medications
- Identify drug therapy problems, then intervene by collaborating as a team to manage issues
- Help prescribers assess whether medications fit with older adult's life circumstances
- Facilitate discussions about whether the benefits of medications outweigh potential harm



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Talk with the patient and prescriber

- I notice that you're having a harder time than usual organizing your thoughts today – do you notice that?*
- Perhaps we could talk with your doctor about that*
- Mrs. Jones was really confused in her visit with me today, and that's so unusual. I noticed that she recently started Ditropan – might that be having an effect?*



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Class Activity:
Name that...Medication Side-Effect Cause

- What kind of medications can cause ill-fitting dentures?
- What kind of medications can cause urinary retention?
- What kind of medications can cause disinhibition?
- What kind of medications can cause vivid dreams or nightmares?
- What kinds of medications have Anticholinergic effects?
- What kind of medications causes orthostatic hypotension?
- What kind of medications causes High Fever, confusion and rapid heart rate?



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TIME FOR A BREAK

Stand up, Stretch, Walk Around!



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Depression, Anxiety, and PTSD in Older Adults

There are differences in older adult symptoms, assessment, and treatment of these mental health issues.




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Depression
NOT a normal part of aging.




  

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Depression

- Unique presentation in later life
 - Less likely to report depressed mood
 - More likely to report anhedonia, sleep, fatigue, being slowed down, hopelessness, overall body aches and pains, and memory problems
- "Minor" or subsyndromal depression
 - ~15% in the community
 - Associated with decreased function in later life




  

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Depression Prevalence

- Depression is not a normal part of aging
- Prevalence lower for older adults
- Prevalence higher in:
 - LGBTQ community
 - Minority groups
 - Multiple medical problems
 - Long-term care settings




  

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Depression and Health Behavior

- Depression can lead to poor self-care
- Non-adherence with medication regimens
- Decreased levels of physical activity
- Poor dietary habits
- Exacerbates existing medical conditions
- Causes medical conditions




  

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Depression Assessment

- Clinical interview
- Self-report measures
- Interviewer administered measures
- Family or caregiver report, as appropriate
- Consider reciprocal relationships of depression, physical illness, cognitive impairment




  

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Self-Report Response Style

- Older adults may under-report symptoms
 - Males, the oldest cohorts, cognitive impairment
 - Consider involving family members, close friends or caregivers
- Self-report measures challenges
 - Low literacy
 - English as a second language
 - Poor eyesight
- Testing administration factors
 - Likert scales can be confusing
 - low education or cognitive impairment
 - Measures developed for and validated with older adults
 - Somatic symptoms

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Validated Depression Screening Tools

- GDS: Geriatric Depression Scale
- PHQ-9: Patient Health Questionnaire – 9 Item

GERIATRIC DEPRESSION SCALE (GDS-15)

Issues:
The GDS is a screening tool and not a diagnosis. Where a score of more than five is indicated, a more thorough clinical investigation should be undertaken. Fisher et al.'97 have established that the GDS is a generally valid measure of the mild to moderate depressive symptoms in Alzheimer patients with mild to moderate dementia. The chart should be interpreted to reflect the following information.

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities or interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?		
5. Are you in good spirit?		
6. Are you afraid that you will lose your mind?		
7. Do you feel happy most of the time?		
8. Do you feel helpless?		
9. Do you prefer to stay at home?		
10. Do you feel that you are not interested in anything?		
11. Do you think it is worthwhile to live?		
12. Do you feel pretty well most of the time?		
13. Do you feel full of energy?		
14. Do you feel that you are not interested in anything?		
15. Do you think that you are not interested in anything?		

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "0" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so restless or so fidgety that you feel other people would notice	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

When a score of more than 5 is indicated, a more thorough clinical investigation should be undertaken.

Score: _____ / 15

One point for No to question 15

One point for Yes to other questions

Normal ≤ 2

Mildly Depressed 3-5

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Differential Diagnosis

- Depression vs. dementia vs. both is common diagnostic question
- Loss of energy, feelings of inappropriate guilt or regret, and thoughts of suicide are indicative of depression
- Difficulty organizing thoughts, language deficits, and incontinence are more indicative of dementia

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Evidence-Based Treatment for Depression

- Cognitive Behavioral Therapy
- Interpersonal Psychotherapy
- Problem-solving Therapy
- Anti-depressant medication

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Evidence-Based Treatment for Depression

- What matters most to the older adult
- Most older adults prefer psychotherapy, some medication
- Psychotherapy can be as effective as antidepressant medication alone for the older adult with mild to moderate depression
- Antidepressant medication may be appropriate for more severe depression
- Medication adherence to prescribed antidepressants can be a challenge



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Anxiety

The overlap of anxiety and medical conditions is significant.



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Anxiety Disorders in Older Adults

- More likely to say "concern" rather than "anxiety"
- Focused on loved ones, general health concerns, sexual minority status, and the state of the world
- Less likely to describe feeling anxious or depressed and more commonly emphasize physical health or other bodily concerns.



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Anxiety & Medical Conditions




- Overlap with medical symptoms – assess carefully
- Medication side effects may explain some anxiety symptoms
- New onset anxiety in late life may be a symptom of cognitive impairment

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Common Anxiety Disorders in Older Adults




- Anxiety is common in older adults but less common than in younger adults
- Generalized Anxiety Disorder
- Specific Phobias
 - Fear of falling can lead to decreased activity resulting in deconditioning and impaired mobility
- Adjustment Disorder with Anxious Mood

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Screening Tools for Anxiety Validated with Older Adults

GAD-7 Generalized Anxiety Disorder 7 items 4-point Likert	GAI Geriatric Anxiety Inventory 20 items Agree / Disagree	GAS Geriatric Anxiety Scale 30 or 10 items 4-point Likert Subscales: somatic, cognitive, affective	PSWQ / PSWQ-A Penn State Worry Questionnaire 16 or 8 items 5-point Likert
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Evidence-Based Treatment for Anxiety

- Cognitive Behavioral Therapy
- Acceptance & Commitment Therapy
- SSRI/SNRI

**NOT benzodiazepines*

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Trauma and PTSD in Older Adults

Trauma is common in the human experience. Older adulthood can present challenges that may re-activate PTSD symptoms. Trauma informed care supports trauma survivors at multiple organizational levels and settings.



  

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Trauma and Older Adults

- 70-90% of adults experience potentially traumatic event in lifetime
- 20-40% of those develop PTSD
- Lifetime prevalence of PTSD in older adults 4.5%; higher among veterans and marginalized groups
 - Generally lower rates than younger adults

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PTSD in Older Adults

- Delayed onset rare; more likely increase from sub-threshold symptoms
- Symptoms may emerge during role changes
 - Retirement
 - Bereavement
 - Medical illness
- Cognitive Impairment
- Clinicians less likely to detect PTSD in older adults

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Impact of Trauma and PTSD

Psychological <ul style="list-style-type: none"> • Mood disorders • Anxiety disorders • Substance use disorders • ↓ Psychosocial functioning • Coping behavior • Suicidality 	Medical <ul style="list-style-type: none"> • HTN, cardiac, stomach ulcers, gastritis, arthritis, metabolic syndrome, ↓ physical functioning, pain Pathways: <ul style="list-style-type: none"> • Physical trauma • Physiological consequences of chronic stress and hyperarousal 	Cognitive <ul style="list-style-type: none"> • Cog impairment • Dementia Mechanisms: <ul style="list-style-type: none"> • Oxidative Stress • Substance use • Chronically disturbed sleep Risk: re-exposure	Premature Aging <ul style="list-style-type: none"> • ↓ Leukocyte telomere length • ↑ Pro-inflammatory markers <ul style="list-style-type: none"> • IL-6, IL-1β, CRP, TNF-α • Medical comorbidity • Earlier mortality
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CENTER **CATCH-ON** **RUSH**

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Trauma Informed Care with Older Adults


Settings <ul style="list-style-type: none"> • General healthcare settings • Emergency department • Inpatient geriatric units • Hospice 	Triggers <ul style="list-style-type: none"> • Physical touch • Personal care • Physical exposure to staff • physical restraints • Unfamiliar sounds • Pain • Isolation
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CENTER **CATCH-ON** **RUSH**

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Specific Strategies

- Create a calm environment: pleasant color schemes and minimal clutter
- Establish visiting hours and quiet hours– including older adult preferences for these hours in residential settings
- Knock gently when entering patient spaces and introduce oneself each time
- Help the older adult feel in-control and safe during personal care or procedures by asking permission and narrating what is being done throughout the process
- Elicit the older adult's preferences about staff, such as preferring only female staff or an older care provider
- Delirium precautions for those at risk
- Involving mental health staff in the treatment team



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Evidence-Based Treatment for PTSD


- Exposure Therapies
- Narrative Exposure Therapy
- Cognitive Processing Therapy
- Lack of evidence for psychopharmacology in PTSD



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Communicating about Mental Health Treatment

- Dispel myths
- Use plain language to reduce stigma
- Use terms "counseling" or "talk therapy"
- Discuss the importance of treating depression
 - Medical sequelae
 - Older adults can feel better/do what matters most
- If appropriate, involve family with older adult's permission
- Explain how Psychotherapy works
 - Focuses on today's problems, time limited, and research shows that it works
 - Covered by insurance
- Address fears about medication
 - Not addictive and has few side effects
- Provide assurance about availability to answer questions or address concerns throughout treatment



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Notes about CBT with Older Adults

- CBT model includes physiology for older adults
 - Chronic illness, pain, and other physical symptoms are common factors in older adult anxiety and directly impact thoughts, emotions, and behavior
 - Relaxation training can help
- Slow, rather than deep breathing is more feasible and helpful for those with lung disease or reduced lung capacity
- Cognitive restructuring modifications
 - Ageism
 - Cognitive Impairment



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Prevention

- Screening
- Maintain physical, cognitive, and emotional health
- Encourage self-care activities
- Encourage older adults to engage in What Matters
- Engagement in self-care activities may also be part of formal psychotherapy treatment



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Mrs. Martinez

What mental health disorders is Mrs. Martinez at risk for?



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Mrs. Martinez's Story Unfolds


- Went to PCP last week for a regular check-up for diabetes
- PCP asked about mood: "fine"
- Having trouble sleeping for the past month
- Fatigue
- A self-proclaimed worrier: "There are so many things to worry about!"
- Hasn't felt like doing things
 - Going for walks with grandchildren
 - Coffee with my friend after church



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Questions: Mrs. Martinez

- What aspects of Mrs. Martinez's mental health do you need to learn more about?
- Which screening measures would you use?
- What medical issues need to be ruled out before diagnosing Mrs. Martinez with a mental health disorder?
- What cultural factors need to be considered for an older adult immigrant in assessment and treatment options?



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TIME FOR A BREAK




Stand up, Stretch, Walk Around!



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Suicide
Take suicidal thoughts very seriously.



 

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Suicide among older adults

- White males age 85+
- 85-90% older adults who die by suicide had major mental illness
- 1 of every 4 older adults who attempts suicide dies, compared to 1 in 25 for younger adults
- Risk factors: mental health disorder, grief, lack of purpose or meaning, dementia, social isolation and loneliness

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Warning Signs

Verbal warning signs

- "What is the point of this all anyway?"
- "No one would miss me if I was gone"

Behavioral warning signs



- Failed suicide attempt
- Giving away all of one's possessions, self-neglect, stockpiling medications

Contextual or situational warning signs


- Relocation, death of a loved one, significant change in medical or functional status

Mental Health Warning Signs

- Depression with anxiety, irritability, guilt, rigidity and impulsiveness, appetite change, sleep disturbance, abrupt recovery from severe depression




 

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Suicide Assessment




- Within a month before their suicide, ~45% of have seen primary care; 20% have seen mental health professional
- Asking about suicide risk does not encourage an attempt
- Ideation, intent, plan
 - Distinguish between wishes for death and plans to die
- Consider the means
- **Columbia-Suicide Severity Rating Scale (C-SSRS)**

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Suicide

<h4>Internal Protective Factors</h4> <ul style="list-style-type: none"> • Coping skills • Adaptive skills • Sense of humor • Engagement in social interests • Ability to recognize success 	<h4>External Protective Factors</h4> <ul style="list-style-type: none"> • Strong family and community network • Engagement with religious groups • Supportive and engaged health care team
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Prevention

- Prevention saves lives
- Multi-level prevention initiatives provide the greatest benefit
 - Universal
 - National Suicide Hotline: **988**
 - Selective
 - Indicated prevention


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Passive Suicidal Ideation


- Thoughts that life is not worth living, rather be dead
- Deny thoughts of self-harm
- May not represent an acute risk for suicide
- Require further assessment to determine the most appropriate level of treatment
- Frequent follow-up suicide assessment recommended

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Active Suicidal Ideation

- Endorses thoughts of suicide (without plan or intent)
- Trained professional must create a safety plan with the older adult, or activate institutional safety plan if available
- Safety plan
 - Contact family and friends to support the older adult, with permission
 - Family members can be informed without patient permission only when imminent risk
 - Remove weapons, alcohol, medications, etc. from home
 - Encourage activities that reduce isolation/increase pleasure
 - Identify protective factors against self-harm
 - National Suicide Prevention Lifeline: **988**
- Frequent follow-up assessment of suicide risk



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Expert Video Discussion

- As discussed by Dr. Gregg, what are the main differences between older and younger adult suicide?
- Dr. Gregg presented a case in which he described his process of working with an older adult who was experiencing suicidal ideation (SI). What would you like to incorporate into your practice based on what he shared regarding assessing and treating older adults with SI?



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TIME FOR A
BREAK



Stand up, Stretch, Walk Around!




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Serious Mental Illness

SMI includes many disorders that often keep people from reaching their goals; interventions and advocacy can help






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Defining Serious Mental Illness

- SMI is an aggregate term for a group of diagnosis that cause significant problems in daily living
- SAMHSA describes SMI as: "...a diagnosable...disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities"

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Diagnostic Overview: Serious Mental Illness

- Major Depressive Disorder
- PTSD
- Psychotic Disorders
- Schizophrenia
- Schizoaffective Disorder
- Bipolar Disorder






  

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Impact on Health and Wellness

- Life expectancy reduction of between 10 and 20 years for people with SMI
 - Health behaviors
 - Access to medical services
 - Social isolation
- Chronic medical issues
- Social isolation
- Stigma and Biases
- Lack of Valued Social Roles

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Major Depressive Disorder in Older Adults as SMI

- Older adults with MDD are more likely to report:
 - Memory problems, generalized physical pain, decreased functioning
- Older adults with MDD with psychotic features may:
 - Present with more severe symptoms
 - Be misdiagnosed with dementia

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PTSD in Older Adults as SMI


- Those with traumas at a later age have different symptoms patterns
- PTSD is associated with a greater risk of developing dementia
- *PTSD is categorized as a SMI when symptoms result in significant impairment in life activities*

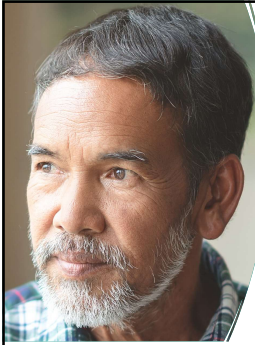
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Psychotic Disorders and Older Adults

- Psychotic disorder is term applied to many diagnoses that include delusions and/or hallucinations
- Experiences of delusions and hallucinations themselves are common
 - Lifetime prevalence rate of 25% but disorders with these symptoms are much less common
- Schizophrenia, bipolar disorder, schizoaffective disorder, depression can all include psychotic symptoms
- Psychotic symptoms may be caused by non-psychiatric conditions

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Overview: Schizophrenia and Older Adults

- National Institute of Mental Health “...characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions”
- Course varies, typically life-long
- People with schizophrenia and other SMI live longer than in past, but still have shorter lives and often “age faster” than those without SMI



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Schizophrenia and Aging


- Symptoms and related concerns may evolve with age—with positive symptoms often improving
- Social determinants of health typically affect people with schizophrenia
 - Poverty
 - Unstable housing
 - Poor medical care



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Cognitive Aging and Schizophrenia

- Decline in cognitive functioning for up to a decade before onset of psychotic symptoms is common
- People with schizophrenia have similar trajectories of cognitive aging as other older adults
- Older adults with schizophrenia have greater cognitive difficulties because cognitive decline starts earlier



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Aging, Schizophrenia, and Social Connections

- Social networks of people with psychosis, specifically schizophrenia, are not as robust
- Social connections have been found to help coping, preserving a sense of identity, improving quality of life
- Psychosocial functioning of people with schizophrenia tends to improve with age
 - Often doesn't translate into improved social connections and the related benefits



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Other Treatment Issues

- Older adults with schizophrenia and other SMI diagnoses are subject to overlapping concerns:
 - Depression, anxiety, dementia, grief, trauma, substance use
 - Any other issue that could apply to older adults in general




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Schizoaffective Disorder

- Lifetime prevalence rate is approximately 0.3%
- Few studies of aging with schizoaffective disorder
- Some studies have indicated symptoms can ameliorate with age
- Treatment includes antipsychotic, antidepressant, mood stabilizing medications, psychotherapy, psychosocial interventions






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Bipolar Disorder


- Typical onset in adolescence/early adulthood
- 1-5% of older adults have bipolar disorder
- Depressive states are more common with older adults;
Treatment: Antipsychotics, mood stabilizers, benzodiazepines, and psychosocial interventions




  

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SMI Confounds

- Symptom overlap of serious mental illnesses make diagnosis challenging.
- Other confounds of older adult SMI diagnosis include physical health concerns, substance use, and dementia.






  

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SMI and Dementia Symptoms: Commonalities and Differences

- Common symptoms between SMI and dementia
 - Hallucinations, delusions, and psychomotor changes
- Symptoms have different etiologies and different expressions
- Not possible to accurately determine an SMI or dementia diagnosis based on different experiences of hallucinations and delusions alone




  

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**Medications:
Older Adults with SMI**

- Antipsychotic medications
- Mood stabilizing medications
- Benzodiazepines
- Concerns with medication side effects
 - Need to discuss cost vs. benefit
 - Side effects may increase with age
 - Many of these medications are on Beers List

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**Evidence-Based
Treatments
for People with SMI**

- Psychosocial Rehabilitation
- Assertive Community Treatment
- Cognitive Behavioral Social Skills Training (CBSST)
- Social Skills Training
- Integrated Illness Management and Recovery (I-IMR)
- Cognitive Behavioral Therapy for Psychosis (CBT-p)

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Social Stigma, Self-Stigma

- Overlapping stigma of SMI + stigma of Age
- Stigma:
 - limits opportunities for people with serious mental illness
 - leads to increasing discrimination and barriers to care seeking
- Self-stigma:
 - is common
 - impacts social functioning, quality of life, meaning in life



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Valued Social Roles

- The “parts” we play within society
- Social roles hold different levels of value within a society
 - Higher value: a worker, a parent, a rich person, a student
 - Lower value: ill person, an old person, or a poor person
- Roles may change over time
- Role loss or inability to hold a desired valued role can lead to poorer mental health and lower life satisfaction





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Vignette and Discussion: Denise McDonald

Things to listen for:

- What types of things is Denise struggling with?
- What does she want her life to be like?
- What is important for her treatment providers to consider?





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SMI and Recovery-Oriented Care in Older Adults

- Rooted in the US social justice movements of 1960s
- Intent was to reform mental health care/empower patients
- SAMHSA developed a working definition and outlined ten guiding principles:
 - “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”
 - Four dimensions: health, home, purpose, and community
 - Principles include “recovery is person-driven,” “recovery is holistic,” “recovery is based on respect”





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4Ms Framework and Recovery-Oriented Care

- Recovery-Oriented Care aligns strongly with the 4Ms framework of an Age Friendly Health System
- The 4Ms framework => aligning with older adult health goals and Recovery-Oriented Care => self-determination and self-direction
- Recovery is rooted in the uniqueness of individuals mirrors the interconnectedness of the 4Ms for each individual
- Differences: 4Ms => shape physical and behavioral healthcare and Recovery model => emphasizes social/cultural principles, personal beliefs within



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Cognition

Decline in some areas is normal; dementia is not a part of normal aging.



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most affected by normal aging

Frontal lobe

Parietal lobe

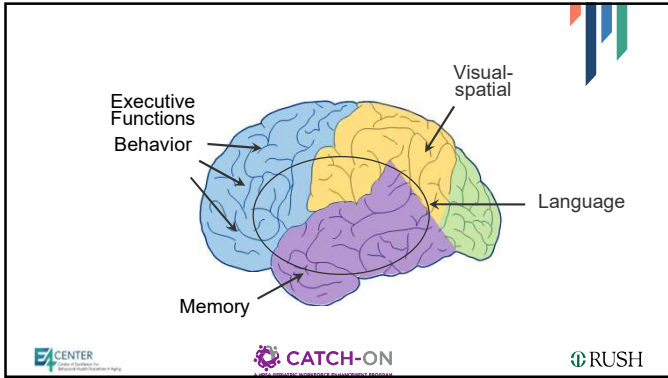
Temporal lobe

Occipital lobe

Vision



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Normal Aging

- Attention
 - Sustained: stable
 - Selective: slows
 - Divided: declines
- Memory – some change
- Language
 - Some word-retrieval problems
 - Otherwise, well-preserved
- Processing speed – declines
- Visuospatial abilities – stable
- Executive function – some decline
 - Abstract reasoning, mental flexibility, problem-solving, planning, etc.

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CATCH-ON
Aging Memory Assessment Program

RUSH

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Not Normal Aging

- Sustained attention
- Certain kinds of memory problems
- Difficulty understanding or expressing language
- Visuospatial problems
- Significant changes in personality and behavior
 - Social behavior
 - Judgment
 - Awareness

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Aging Memory Assessment Program

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Two kinds of memory

Explicit/Declarative Memory

- Conscious recollections of facts, experiences, etc.
- Declines with age

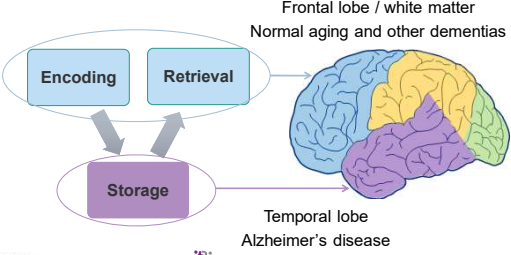
Implicit / Non-declarative

- Memories acquired and used unconsciously (e.g., skills, like riding a bike)
- Stable with age




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Stages of Explicit Memory



Frontal lobe / white matter
Normal aging and other dementias

Temporal lobe
Alzheimer's disease



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Treatable Cognitive Impairment

- Depression
 - Age-appropriate mood screening
- Nutritional deficiency
 - Medical evaluation
- Delirium
 - Acute confusional state due to a medical condition






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Delirium




- More serious in older adults
 - Slower onset
 - Slower recovery
- Many causes
 - Medications are #1
- Risk factors
 - Older age
 - Multiple medical conditions
 - Dementia

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Delirium


- Symptoms
 - Attention/arousal
 - “Waxing and waning”
 - Disorientation
 - Perceptual disturbance
 - e.g., hallucinations
 - Sleep-wake disturbance
- Two presentations
 - Hyperactive
 - Hypoactive




  

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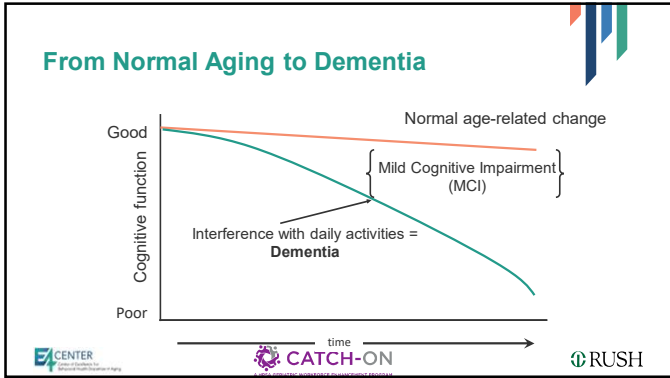
Dementia: Umbrella Term for Multiple Diseases

- “Significant” decline in cognition or behavior
- Interferes with a person’s ability to carry out daily activities
- Many causes
- Some reversible (e.g., delirium)



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Two types of memory problems

Storage

- Inability to make/store new memories
- Poor memory for recent events
- Memories made prior to the disease are preserved
- Little to no insight

Encoding and retrieval

- Memories do get made; inefficient, inconsistent
- Hints and cues can help
- Patients usually aware of the problem

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Types of Dementia

Alzheimer's Disease

- Most common: 60-80% of cases
- Inability to make/store new memories
- Poor memory for recent events
- Naming problems early on

Vascular disease

- 2nd most common cause of dementia
- Microvascular ischemic disease; stroke
- Memory encoding/retrieval

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Types of Dementia




Frontotemporal degeneration

- 5-10% of cases
- Most common early-onset
- Profound changes in personality/behavior
- Executive dysfunction
- Complete lack of insight

Dementia with Lewy bodies

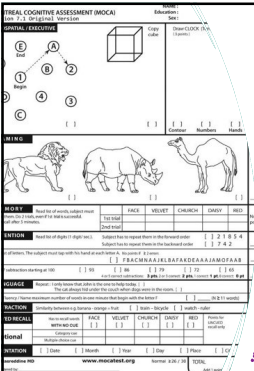
- 3rd most common degenerative cause
- Fluctuating course
- Visual hallucinations, parkinsonism

Encoding and retrieval memory problems








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Assessing Cognition






- Clinical interview
- Collateral information
- Daily activities
- Screening
- Medical evaluation
- Neuropsychological evaluation
 - Normative data
 - Premorbid estimation


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Screening Tools for Cognitive Impairment

Mini Mental Status Exam (MMSE)	Montreal Cognitive Assessment (MoCA)	St. Louis University Mental Status Exam (SLUMS)	Delirium Screening
30 points	30 points	30 points	Confusion Assessment Method (CAM)
Not in public domain anymore	Public domain; requires paid training	Public domain	4AT UB-2

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Dementia Prevention

- Regular physical exercise
- Heart-healthy diet
 - Mediterranean diet
 - MIND diet
- Smoking cessation
- Healthy sleep habits
- Adherence
 - Controlling chronic conditions (diabetes, high blood pressure) high cholesterol
- Remaining cognitively active and socially engaged

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Managing Cognitive Impairment: Communication

- Remove distractions
- Use short, direct sentences and allow time to process
- Ask one question at a time
- Don't use elderspeak!
- Alzheimer's disease: do not remind; just repeat
- Others: provide context to trigger memory

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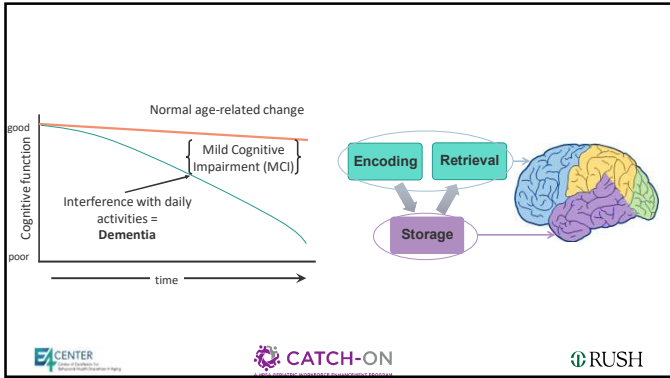


Managing Cognitive Impairment: Behaviors

- Sometimes the only way a person can communicate
- Is there an unmet need?
 - Pain, emotion, environment, boredom, need for interaction
 - Solution: meet the need
- Is behavior caused or reinforced by caregivers or something in the environment?
 - Modify the environment
 - Change caregiver behavior
- Medication only if safety risk to self or other – last resort

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Discussion Questions

- What kind of memory problem does Mrs. Jing seem to be having?
- Which diagnosis fits best? Normal aging, MCI, dementia, or delirium?
- What disease is the most likely cause of her memory problems? What information did you use to rule out other causes?
- What should the next steps be for Mrs. Jing and her son?



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TIME FOR A
BREAK



Stand up, Stretch, Walk Around!



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Ethical Considerations in Older Adult Care



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Ethical Principles

- Autonomy**
 - Right of every person to make own choices, to receive and give information, to consent based on personal values/beliefs
- Beneficence**
 - Moral obligation to act in patients' best interests
- Nonmaleficence**
 - Do no harm and make efforts to maximize safety
- Justice**
 - Treat patients fairly, equitably, justly
 - Avoid making decisions influenced by ageism, age-discrimination, other bias





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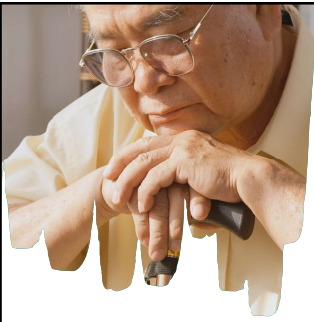
Ethical Dilemmas

- Ethical dilemmas are created when ethical principles conflict
- Not always avoidable
- Clinician or care team decides best course of action
- Knowledge about common ethical dilemmas in older adult care can help avoid and resolve them






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Ageism and Ethical Considerations

- Self-evaluation is imperative
- Personal reactions can affect clinician decision making
- Decisions should be made with structure and balance
- Recognizing ageist beliefs and implicit bias helps make decisions more objective



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Mrs. Greene




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Discussion Questions

1. What are some examples of competing ethical principles illustrated in Mrs. Greene's situation?
2. In what ways might ageism be affecting the decision-making process of the care team, the family, and Mrs. Greene?




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Informed Consent

- Ethical and legal obligation
- Be mindful of informed consent process
 - Older adult capable of providing consent
 - Assure understanding of the treatment procedures, risks and benefits, and alternative treatment options
- Surrogate decision maker
 - Ideally, with the assent of the older adult, to the extent they can engage in the process



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Jonsen's Four Topic Approach

Clinical Assessment

- Ethical principles: beneficence and nonmaleficence
- Explore the medical problem, treatment options, goals of care
- Clarify nature of the problem and expected outcomes

Patient Rights and Preferences




- Ethical principles: respect for patient autonomy

Quality of Life

- Ethical principles: Beneficence, nonmaleficence, autonomy
- Explore expected quality of life associated with all options

External Forces and Context

- Ethical principle: Justice
- Consider pertinent conflicts of interest

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Mrs. Greene

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Exercise and Case Discussion

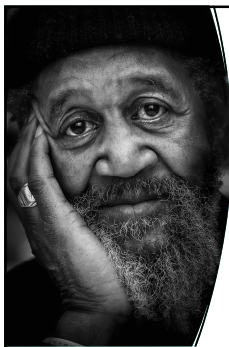
<p>Clinical Assessment</p> <p>-What are ways we can enhance her likelihood of success in being prepared for discharge home, if that is her wish?</p> <p>-What are the risks and benefits involved with all her options (home, nursing facility, or otherwise)?</p>	<p>Patient Rights & Preferences</p> <p>-What should we consider regarding decisional capacity?</p> <p>-What do we know about <i>What Matters</i> to her?</p> <p>-Are there biases in her expectations of her options?</p>
<p>Quality of Life (QoL)</p> <p>-What are the QoL consequences related to her options?</p> <p>-Are there personal biases that might affect a clinician's ability to judge Mrs. Greene's quality of life?</p>	<p>External Forces and Context</p> <p>-How might her team emphasize the principle of justice in this case?</p> <p>-Are there conflicts of interest based on patient factors, clinician factors, or cultural beliefs?</p>

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4Ms Complex Case Discussion

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Mr. Smith

- 79 year-old black man
- 11th grade education, retired construction worker
- Never married, no children, lives alone in apartment above nephew's garage
- History of trauma related to childhood physical abuse
- Diabetes, COPD, arthritis in both knees
- Difficulty sleeping for "as long as he can remember"
 - Prescribed Xanax for 10 years by PCP

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Discussion

- Mr. Smith walked into the kitchen at 10PM with blood on his head asking if his nephew could take him to work because he was too late to take the bus
- The ER doctor determined his head wound to be a result of a fall
- CT scan: no bleeding on the brain
- Mr. Smith was discharged from the hospital the next day with home health
- The rural hospital also provided a referral for a mental health evaluation and follow-up treatment if necessary
- You are tasked with conducting a mental health examination and making treatment recommendations

How would you use the 4Ms to assess and address Mr. Smith's needs?

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4Ms in Behavioral Health (4M-BH) Checklist

4Ms	Assess	Date	Act On	Date	Notes (by PIP/PH)
What Matters	<input type="checkbox"/> Ask about matters in real life, health, and healthy care <input type="checkbox"/> Links: <input type="checkbox"/> Information <input type="checkbox"/> Ability <input type="checkbox"/> Medication		<input type="checkbox"/> Document what matters where the team can access. <input type="checkbox"/> Assure PCP/CM in chart (EM) completes PCP/CM form (EM) document patient preference not to have care.		<input type="checkbox"/> Complete Adult Daughter is POC, daughter and PCP have POC.
Medication	<input type="checkbox"/> Assess medication list for duplications <input type="checkbox"/> Links: <input type="checkbox"/> What Matters <input type="checkbox"/> Ability <input type="checkbox"/> Medication		<input type="checkbox"/> Create plan to address SDOH needs <input type="checkbox"/> Discuss any concerns about medication, treatment adherence, or side effects with prescriber, pharmacist, or other providers depending on high-risk medications. <input type="checkbox"/> Screen for alcohol and prescription, over-the-counter, prescribed medication misuse.		
Mental Health	<input type="checkbox"/> Links: <input type="checkbox"/> What Matters <input type="checkbox"/> Ability <input type="checkbox"/> Medication		<input type="checkbox"/> Create a treatment plan based on cognitive status and other factors. <input type="checkbox"/> Create suicide prevention plan as needed, per clinic protocol. <input type="checkbox"/> Screen for cognitive impairment including caregiver observations. <input type="checkbox"/> Complete assessment, identify caregiver needs, as indicated.		
Mobility	<input type="checkbox"/> Links: <input type="checkbox"/> What Matters <input type="checkbox"/> Ability <input type="checkbox"/> Medication		<input type="checkbox"/> Screen for falls and risk. If falls in last 12 months or fear of falling, or fall report of mobility on record. <input type="checkbox"/> Provide referrals and connect to support for family caregivers, as needed. <input type="checkbox"/> Document caregiver needs. <input type="checkbox"/> Refer: Safe mobility plan for fall risk.		

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Question for reflection:

What are the biggest take-away(s) from today for you?

<https://bit.ly/OAMHDay2>



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