COMPLEX BEHAVIOR MANAGEMENT IN OLDER ADULTS

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I have no actual or potential conflict of interest to disclose.
CASE STUDY

70 year old right handed female with Hypertension, Diabetes Mellitus, Chronic renal insufficiency, Osteoarthritis, Depression, and chronic insomnia

On three anti-hypertensives, newly initiated Insulin therapy, antidepressant, and as needed anxiolytic.

Had two ICU stays for hypertensive crisis in the last 3 months

Recently bereaved after 50 + years of marriage – is grief stricken, not sleeping, BP and DM out of control with stress

Develops acute abdominal pain at 4 am that has her writhing in pain. Results in ED visit with numerous tests and no answers. Gets narcotic for pain relief in ED.

Returns home after spending all morning and afternoon in ED. Restless, unable to sleep, falls in the middle of the night while going to the bathroom.

Fractures right wrist.
LEARNING OBJECTIVES

- Recognize the complexity of interaction between cognition, physical health, environment and psychological issues in behavioral expression.
- Effective management by understanding the reasons for the behavior.
WHO ARE WE TALKING ABOUT?

- Longevity revolution: US population of 65 (+)
  - In 2011 – 40 million; 2030 – 72 million
  - Since January 2011, everyday 10,000 individuals turn 65
  - In 2030, 1 in 5 Americans will be 65 and over – 20%

- CDC’s The Behavioral Risk Factor Surveillance System
  - 20% of people age 55 years or older experience some type of mental health concern.

- Mental health concerns are a complex interplay of Life issues and Mental health issues

Sources – Federation for aging research, CDC, USC Leonard Davis school of gerontology
WHO ARE WE TALKING ABOUT?

Life issues such as

- Physical illness - 2 in 3 older adults has at least 1 chronic condition
- Limited mobility
- Stressful life events such as
  - Loss of independence
  - Loss of spouse/partner
  - Loss of socio economic status – 15 % of older adults live in poverty
  - Moving out of home
- Mental health concerns include anxiety, severe cognitive impairment, and mood disorders

Sources – Federation for aging research, CDC, USC Leonard Davis school of gerontology
WHO ARE WE TALKING ABOUT?

- The number of new nursing home admissions with mental illness other than dementia is increasing.
- In 2005, of the nearly 1 million new admissions,
  - 19% were admitted with mental illnesses other than dementia, whereas 12% had dementia only (Grabowski et al., 2009).
- In 2009, Estimates of Nursing home residents with mental illness was 7% in Medicaid claims 33% NNHS (National nursing home survey) and 46% in the minimum data set (MDS).
- Using data from the Medicare Current Beneficiary Survey and other sources, a 2005 study approximated that 27.6% of Medicare beneficiaries in nursing homes received an antipsychotic prescription (Briesacher et al., 2005).
WHY ARE WE TALKING ABOUT THIS?

- During the deinstitutionalization (1960’s and 1970’s) era, the number of elderly persons in psychiatric hospitals decreased by about 40%, while the mentally ill in nursing homes increased by more than 100% (Institute of Medicine 1986)
- Nursing home reform measures were enacted in mid 80’s to prevent the use of nursing homes as alternatives to state psychiatric hospitals
- Laws and policies that shape our/your work
LAWS AND POLICIES

- The Omnibus Budget Reconciliation Act (OBRA) of 1987
  - Required that states implement a process for screening for serious mental illness among applicants to nursing homes.
  - Under these guidelines, Nursing facilities prohibited from admitting any individual with SMI unless the state mental health authority determines that nursing home level care is appropriate for that individual.
  - Limited the use of psychotropic medications in residents of long-term care facilities. Emphasized documentation of necessity and periodic trials of medication withdrawal.

- The Americans with Disabilities Act (1999) made it discriminatory to institutionalize a person with disabilities who wished to live in the community. *(LC v. Olmstead)* - the Olmstead decision
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

- Federal requirement to ensure individuals are not inappropriately placed in nursing homes for long term care.
- Intended to move services away from institutional care.
- Advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care.

Source: Medicaid.gov
SIGNIFICANCE

- A 2005 study using MDS data compared the demographic, clinical, and functional characteristics of persons with and without serious mental illness newly admitted to nursing homes.
  - 90 days after initial admission, individuals identified as Low care status (minimal physical limitation and ADL assist)
  - Persons younger than 65, with serious mental illness (33%) without serious mental illness (8.5%)
  - Persons aged 65 and older with serious mental illness (14%) without serious mental illness (6.6%).

- Conclusions: Individuals with serious mental illness are younger and more likely to become long-stay residents than those admitted with other conditions.
APPROPRIATELY MATCHED?

- Medicaid beneficiaries with schizophrenia aged between 40 and 64 years are four times more likely to be admitted to a nursing home compared with Medicaid beneficiaries in the same age group without a mental illness. (Bartels et al., 2009)
SMI AND QUALITY OF CARE

- Financial: perverse incentives?
  - For individuals deemed “clinically complex” conditions (e.g., pneumonia, dehydration), a higher rate is paid in the presence of mental illness.
  - Individuals with behavioral problems such as wandering, hallucinations, and delusions can qualify for a higher rate, but only if physical limitations are minimal.
  - For individuals with more extensive physical problems requiring assistance with multiple activities of daily living (ADLs), no additional payment for the presence of behavioral problems.
SMI AND QUALITY OF CARE

- Staff recruitment and retention – increased turnover/burnout
  
  - Nursing home residents with SMI exhibit a greater likelihood of physical aggressiveness and socially inappropriate behavior
  
  - Higher nursing home staff time and effort are required to care for behaviorally disturbed residents' verbal or physically aggressive behavior.
  
  - Direct care staff members have a fixed amount of time to spend with residents
    - compelled to devote more of their time to providing care for difficult-to-ignore needs, OR
    - staff may avoid or stint on care for the residents with SMI, because of the added difficulty.
SMI AND QUALITY OF CARE

- Staff Recruitment and retention – increased turnover/burnout
  - Residents with SMI less likely to have family support and other resources.
  - Have less ability to improve their care through the use of either “voice” (i.e., consumer complaints) or “exit” (i.e., transition to more appropriate setting)

(Grabowski et al. 2010).
WHAT DO WE NEED TO KNOW?

- Understand what we are witnessing
  - is it the psychiatric illness or the physical illness?
  - is it the impact of the treatment?
  - is it the impact of inadequate treatment?
  - is it a misdiagnosis?
DIAGNOSIS

- The diagnostician is a detective.
- Using clues drawn from symptoms, medical tests, pattern recognition, a list of all the possible diagnoses that could explain what is going on is arrived at.
- Then the list is narrowed by eliminating clues that don’t fit.
- Why might misdiagnosis occur – premature conclusion, relying on single source of information, disregarding the valence of the clues!
- What other clues might we consider - Timeline matches changes, but not always, sometimes after years, sometimes preceding the physical signs of illness.
- Atypicality – age of onset, other symptoms inconsistent with primary mental disorder
- Known relationship – MI and depression, pancreatic cancer and depression, Mitral valve prolapse and anxiety, Sleep impairment and restless leg syndrome, Chronic fatigue and Depression, MS and Depression.
- Don’t forget to assess for impact of substance use
PSYCHIATRIC DIAGNOSIS

- Mood disorders
  - Depression
  - Late life depression
  - Bipolar disorders
- Psychosis
  - Primary psychotic disorders
  - Secondary psychotic disorders
- Anxiety disorders
- Cognitive disorders
PSYCHIATRIC INTERVIEW OF OLDER ADULT

- History
  - Symptoms
    - Present episode including onset, duration and change in symptoms over time
    - Past history of medical and psychiatric disorders
    - Family history of mood disorders, psychoses, substance use and suicide
- Physical examination
  - Evaluation of neurologic deficits, endocrine, occult malignancy, cardiac dysfunction, occult infection
- Mental status examination
HISTORY

- Symptoms may have different attributes – is it normal process of aging? How much distress is it causing? Is there functional interference?
- Avoid over generalization and failure to treat treatable conditions
- Over treating with medication can have consequences too!
- Review common symptoms – weakness, hopelessness, uselessness, isolation, anxiety, sleep disturbance
- Review critical symptoms – suicidality, profound anhedonia, confusion, impulsivity
- Past experiences may not be shared as they may be considered irrelevant
- Must include a thorough medication history
MENTAL STATUS EXAMINATION

- Disturbance of consciousness
- Disturbance of mood and affect
- Disturbance of motor behavior
- Disturbance of perception (hallucination)
- Disturbance of thought content (delusion)
- Disturbance of self esteem, guilt
- Disturbance of cognition – memory and executive functioning
- Suicidal ideation
SUICIDAL BEHAVIOR

- Elderly male, living alone is the highest risk
- Thoughts of death common in late life, but not suicide
- Is life not worth living? Any guilt provoking thoughts? Self accusing thoughts?
- Have you acted on it? Plans?
- Access?
COMMUNICATION

- Older adult may experience disabling anxiety but may not complain,
- Hearing and visual impairment may interfere with communication
- Older adults are cautious and naturally withhold information
- May have own theories as to what is happening
- Do not rush the assessment, do not excessively structure – as you may be out of sync with your patient’s needs.
- Giving time for response is necessary.
- Be aware of clinician attitude (parents) may color engagement
- Above all, treat with respect
DIAGNOSIS – MOOD DISORDERS

- Bipolarity – mixed mood states more common
- Late life depression – often presents as psychotic depression
- Life long Depression – functional impairment may increase in severity
- Reactive depression? Associated with psychosocial stressors
PSYCHOSIS

- Schizophrenia like symptoms in late life
  - Heightened suspicion – life experiences, memory issues
  - Transitional paranoid reaction
    - Gradual transition from without (stealing from me) to within (molestation)
- Late onset Schizophrenia – bizarre delusions of physical or mental influence by others, also somatic, erotic, grandiose; thought broadcasting/thought insertion type symptoms less common
- Late onset delusional disorder – less likely to be bizarre and less impairment functionally.
DIFFERENTIAL DIAGNOSIS MNEMONIC

- Vascular
- Infectious
- Neoplastic
- Degenerative
- Iatrogenic/intoxication
- Congenital
- Autoimmune
- Traumatic
- Endocrine/metabolic
MEDICAL CONDITIONS THAT MAY PRESENT AS PSYCHOSIS

Vascular – stroke, TIA, subarachnoid hemorrhage
Infectious – meningitis, HIV, neuro syphilis
Neoplastic – primary brain tumor or metastasis
Degenerative – Alzheimer’s disease, Huntington’s disease, chronic alcohol use
Iatrogenic/intoxication – medication overdoses, alcohol intoxication or withdrawal
Congenital – Temporal lobe epilepsy
Autoimmune – CNS lupus
Traumatic – traumatic brain injury, traumatic epidural or subdural hematoma
Endocrine/metabolic – hypoglycemia, hypo- or hyperthyroidism, hypercalcemia, hepatic or uremic encephalopathy, acute intermittent porphyria
MEDICAL CONDITIONS THAT MAY PRESENT AS MOOD DISORDER

Post viral depressive syndromes: especially influenza, infectious mononucleosis, viral hepatitis, viral pneumonia, and viral encephalitis

Malignancy: Cancer of the pancreas commonly presents as depression. Lung Cancer, especially oat cell carcinoma.

Brain tumors, either primary tumors or metastatic, may present with depression

Cardiopulmonary disease with hypoxia (decreased oxygen in the blood): acute hypoxia often leads to symptoms resembling anxiety or panic. Chronic hypoxia may present with lassitude, apathy, psychomotor retardation and other symptoms confused with depression.

Sleep apnea: should be suspected in a patient with sleep disturbance and daytime somnolence

Endocrine System Disorders: Hypothyroidism (underactive thyroid), Hyperthyroidism or thyrotoxicosis (overactive thyroid): usually associated with anxiety but may present as depression, especially in the elderly who may have few classical signs of thyroid disease.
MEDICAL CONDITIONS THAT MAY PRESENT AS MOOD DISORDER

Adrenal hypofunction (Addison's Disease), Adrenal hyperfunction (Cushing's Disease), Hyperparathyroidism, Post-partum, postmenopausal, and premenstrual syndromes. Diabetes

Autoimmune disorders: Collagen: Vascular Diseases, Systemic lupus erythematosus (SLE)

Central Nervous System Diseases : Multiple Sclerosis, Sub dural hematomas (bleeding under the dural sack that surrounds the brain). Tumors - Masses, especially in the frontal and temporal areas, can grow for years and cause psychiatric symptoms before any focal neurological abnormality is apparent.

Complex partial seizures

Medications : Antihypertensive medications, Digitalis preparations, along with a variety of other cardiac medications, Indomethacin and other non-steroidal anti-inflammatory medications, Anxiolytics have been implicated both in causing depression and making it worse in susceptible individuals, Steroids including prednisone and cortisone
MEDICAL CONDITIONS THAT MAY PRESENT AS ANXIETY

Substance use – WITHDRAWAL
Somatic manifestations of caffeinism are similar to symptoms of anxiety disorders.

Cardiac - SVT, myocardial infarction (MI), coronary insufficiency, congestive heart failure, Mitral valve prolapse

Pulmonary - Asthma, COPD

Endocrine - Hyperthyroidism, Pheochromocytoma causes catecholamine release and may be misdiagnosed as anxiety, Congenital adrenal hyperplasia (CAH) in women

Metabolic - Hypercalcemia and hypocalcemia, Addison’s disease, Cushing’s syndrome,

Herbal supplements may have side effects such as nervousness and insomnia. Others - temporal lobe epilepsy, vertigo and carcinoid
DELIRIUM – BRAIN ATTACK!

- An acute change in mental status transient, usually reversible, fluctuating disturbance in attention, cognition, and consciousness level.
- Causation not known, but involves cholinergic neurons, inflammatory markers and cerebral metabolic processes,
- Not adequately recognized.
- Can present with
  - Agitation/Aggression
  - Paranoia/hostility
  - Social Withdrawal/isolation (subacute)
- Almost always due to a medical condition
- Addressing the medical condition will clear the delirium
DEMENTIA

Dementia - Loss of brain function affecting memory, behavior, learning and communication

Loss of connection between neurons, cell death and neuronal loss at faster rate

Age is a risk factor for dementia but dementia is not part of normal aging

Most common type is Alzheimer’s,

Other types – frontotemporal, vascular, Lewy body dementias, dementia associated with neurological conditions

Most people have combined injuries

Classification –

   - Cortical vs subcortical can help you anticipate behavior patterns

   - Reversible versus irreversible (helpful only to ensure you are considering treatable conditions)
SYMPTOMS

- Progressive memory loss
- Inability to concentrate
- Decrease in problem-solving skills and judgment capability
- Confusion
- Hallucinations and delusions
- Altered sensation or perception
- Impaired recognition (agnosia) of familiar objects or persons
- Altered sleep patterns
  - Insomnia
  - Need for increased sleep
  - Disturbance or change in sleep-wake cycle
SYMPTOMS

- Motor system impairment
  - Impaired skilled motor function (apraxia)
    - Inability to dress self
  - Gait changes

- Disorientation
  - Person, place, time disorientation
  - Visual-spatial disorientation

- Inability to interpret environmental cues

- Impairment of problem-solving and learning
  - Inability to generalize
  - Loss of abstract thinking
  - Impaired calculating ability
  - Inability to learn
SYMPTOMS

- Memory deficit
  - Short-term memory problems
  - Long-term memory problems
- Impaired language ability (aphasia)
  - Inability to comprehend speech
  - Inability to read
  - Inability to name objects
- Inappropriate speech; use of jargon or wrong words
  - Inability to repeat a phrase
  - Persistent repetition of phrases
SYMPTOMS

- Personality changes
  - Irritability
  - Poor temper control
  - Indecisiveness
  - Self-centeredness
  - Inflexibility
  - Withdrawal from social interaction
  - Decreased ability to care for oneself
  - Decreased interest in daily living activities
Delirium is an acute change in mental state characterized by problems in attention, and behavioral difficulties.

Caused by another condition

Delirium is reversible

Delirium is an emergency!

In a delirious patient – the confusion feels distressing, urgent

Level of consciousness is variable in delirium

Language use – incoherence or inappropriate in delirium,

Sleep – disrupted, sleep/wake reversed in delirium;

Perceptual disturbances - Hallucinations – visual, tactile; Illusions common in delirium

Dementia is a chronic change in mental state characterized by problems with memory, executive function and behavioral difficulties.

Caused by physical changes in the brain

Dementia is progressive.

A long battle!

In dementia – often patient is pleasantly confused.

Not so in dementia (stage of dementia matters)

Word finding difficulty and reduced quality (richness) and quantity.

Sleep – fragmented in dementia

Not necessarily so in all dementias. Alz. with psychosis, LEWY body dementia, Parkinson’s’

- Important to remember individuals with dementia are more vulnerable to becoming delirious.
HOW TO

- Important to have an organizational culture that allows the system to respond and manage the behaviors appropriately.

- Staff skills
  - Describe (what is the problem and whose problem is it), Investigate (what are the contributing factors), Intervene (patient centered, individualized) and Document (learn/prepare for the next time).

- ABC principle

- Med management
  - Basic principles
  - Beers criteria
Activating event results in Behavior that generates a Consequence.
If the consequence is inappropriately managed, the situation can escalate and become a cycle.

- Activating event
  - Environmental factors
  - Physical factors
  - Psychological factors
  - Combination
ENVIROMENTAL FACTORS

- Noise (TV, music, change of shift, alarms, furniture, cart movement)
- Clutter (furniture, people)
- Design Lighting: too bright, not enough
  Carpet design, Tiles
- Temperature (too hot, too cold)
- Recent changes to environment, changes in Staff
- Room mate mismatch
WHAT A NEAT IDEA!

Hogeweyk outside Amsterdam, is a model village with 150 residents

- Like most small villages, it has its own town square, theater, garden, and post office

- Unlike other villages, every resident here has dementia.

- In fact the village is an elder care facility. It has cameras monitoring the residents. The residents shop and eat in restaurants, go about living a normal life all under the watchful eyes of care givers posing as store owners. The town has only one door in and out, all part of a security system designed to keep the community safe.

- Friends and family are encouraged to visit. The residents at Hogeweyk require fewer medications, eat better, live longer, and appear more joyful than those in standard elderly-care facilities.

PHYSICAL FACTORS

- Exacerbation of Chronic medical conditions
  - Example: Blood sugars/blood pressure increases
- Treatment related symptoms
  - Example - Afib treatment, anticonvulsants
- Misidentification of condition resulting in new diagnosis
  - Example - delirium
- Cascading effects of medication prescription – side effects
- Acute illness
PSYCHOLOGICAL FACTORS

- Episode of psychiatric illness
- Recent loss or change in status
- History of trauma, trauma reactivation
WHAT HAPPENS TO THAT PILL?

- Understand physiological changes
  - Volume of distribution to muscle or water is decreased
  - Increased reservoir in fat tissues
  - Protein binding decreased, higher free drug level and toxic effects
  - Drug can be displaced by another
- Start low, go slow
- Avoid reflexive use of medication to manage behavior
- At risk of multiple drug use due to many comorbid conditions
- Avoid medication use without indication
- Avoid sub therapeutic doses of many medications
RISK FACTORS FOR ADVERSE DRUG REACTIONS

- Increasing age
- Increasing number of prescriptions
- Lower body weight
- Hepatic or renal involvement
- Female gender
MEDICATION MANAGEMENT

- American Geriatric Society’s (AGS) Beers Criteria of Potentially Inappropriate Drugs, last published in 2012 and updated in 2015.
- Proven useful in
  - identifying drugs to potentially avoid in older adults,
  - to reduce adverse drug events and drug-related problems, and
  - to improve medication selection and overall medication safety in older adults.
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<td>Guanfacine</td>
<td>For heart failure, diabetes mellitus, chronic kidney disease—ACEI or ARB preferred</td>
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<td>Falls*</td>
<td>For new-onset epilepsy—newer agents preferred (e.g., lamotrigine, levetiracetam and calcium/vitamin D ± bisphosphonate) For neuropathic pain—SNRI, gabapentin, pregabalin, topical capsaicin, lidocaine patch</td>
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<td>Antipsychotics</td>
<td>For delirium—short-term use of antipsychotics (e.g., haloperidol, quetiapine) should be restricted to individuals who are distressed or considered a risk to themselves or others and in whom verbal and nonverbal de-escalation techniques are ineffective or inappropriate For schizophrenia—nonanticholinergic agents may be acceptable (not chlorpromazine, loxapine, olanzapine, perphenazine, trifluoperazine, thioridazine) For behavioral complications of dementia—if nonpharmacological approaches have failed and psychosis and danger to self or others, low-dose nonanticholinergic agent (e.g., risperidone, quetiapine) for shortest duration possible may be acceptable</td>
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WEAVING THE STORY TOGETHER

- Generate a diagnosis only after a good understanding
  - Understanding what underlies behavior is much like peeling the layers of the onion
  - Evaluate non patient factors thoroughly
  - Staff perceptions, interactions
  - Environmental factors
- Non medication interventions should be given preference
- If using medications be aware of side effect profile, drug interactions
  - More is not better
  - Sedation/wakefulness interface – hyper and hypo arousal
  - Work toward the right dose
  - Track response, withdraw meds if feasible
PATIENT CENTERED CARE

- Do not limit to treating the underlying illness
  - Are there factors that predispose to precipitant
- Improve overall conditioning
  - Improve ambulation, gait strengthening
  - May improve self care, dignity
  - Utilize the support of ancillary services
GENERAL CONSIDERATIONS

- Do not assume that patient is making up the symptom because they can do something’s and cannot do other things. Brain Circuits are different and it is easier to think of dementia as short circuiting in the brain rather than complete dead circuitry.

- Utilize previous level of functioning or strengths when identifying a plan for the patient. Playing up to their strengths will be helpful. Remember new learning does not occur. If patient likes to fiddle with things, make them participate in repetitive actions drawing lines, and folding wash cloths.

- Problem solve by looking at all aspects of patient behavior, look for patterns. Think outside the box. Accept that the staff may be setting the tone; be willing to change your tone.

- Consider medical issues such as constipation, thirst, pain.

- Behavior is a means of communicating when language fails.
COMPLEXITIES OF BEHAVIOR MANAGEMENT IN OLDER ADULTS
CASE STUDY

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Develops acute abdominal pain at 4 am that has her writhing in pain. Results in ED visit with numerous tests and no answers. Gets narcotic for pain relief in ED.

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THANK YOU

Organizers of the conference
My mentors
My patients and
The staff at Utah State Hospital