Mental Health for Older Adults

Spring 2011 National Primary Care Conference
1. Wellness
2. Prevention
3. Medications
4. Frailty
5. Mental Health
Session Goals

✔ Review how and why to distinguish three psychiatric conditions in older adults:
  ✔ Dementia
  ✔ Delirium
  ✔ Depression
✔ Briefly review effective treatment.
These 3-D conditions can be comingle:

- Depression
- Pseudodementia
- Delirium
- Dementia
By the end of today’s talk, you will have the knowledge and tools to distinguish them.

Dementia

Delirium

Depression
Dementia

Remains underdiagnosed

Formerly rare; now more prevalent based on aging population

Condition affects patient and caregivers

Major reason for institutionalization

An important co-morbidity and cost-driver

Proper object for screening and early diagnosis?
Dementia: The Imperative

Population is aging
- the baby boomers are here…
- and staying longer!

Prevalence of dementia is
- 15% by age 75
- 35-50% of those 85 and older

Dementia is under diagnosed
- and even with diagnosis under treated
Dementia: The Imperative

Dementia is now the 3rd most expensive medical condition in the US

Delay of even nursing home placement
- by 6 months estimated
- to save the US $4.7 billion annually (1990 $ values)

Dementia and Dementia with Complications
- are recognized as HCC categories
- for payment by Medicare in 2011

Extent of KPNW Underdiagnosis

![Bar chart showing the extent of KPNW underdiagnosis by patient age. The chart compares the prevalence of KPNW diagnoses (KPNW Dx) and the actual prevalence (Prevalence) across different age groups.]

- >65: KPNW Dx > Prevalence
- 65-75: KPNW Dx < Prevalence
- 75-85: KPNW Dx < Prevalence
- >85: KPNW Dx < Prevalence

Kaiser Permanente

KPNW Dx
Prevalence
Under-Treatment of Alzheimer's Disease in US
(in millions)

Prevalence: 4.5
Diagnosed: 3.0
Treated*: 2.0
Treated with AChEIs: 1.0

*Any drug treatment, not limited to AChEIs, Datamonitor 2002

KP Data is very similar to the National data
Dementia: what is it?

More than simply loss of memory

Progressive

Not reversible or caused by other confounders
  - e.g., acute infection, medication, etc

Affects how one functions in daily life
  - assess with IADL/ADL/AdvADL
Dementia – Definition DSM IV

Three criteria are required for a diagnosis

A short term memory deficit that can be demonstrated objectively on cognitive testing

At least one other cognitive impairment such as

- Aphasia – difficulty finding the right words, using the wrong words
- Executive function impairment – difficulty with planning, judgment, mental flexibility, abstraction, problem-solving, etc.
- Agnosia – impaired recognition of people or objects
- Apraxia – impairment of a motor activity to command or pantomime even though the patient understands the request and has no weakness or ataxia that would interfere with performing that task.

Together, these cognitive deficits must result in impairment in performance of daily activities, including significant impairment in social or occupational functioning, and must show a progressive decline from previous functioning.
Individuals with undiagnosed dementia may exhibit behaviors or symptoms that

- Offer a clue to the presence of dementia and
- may be observed by physicians, health care providers, families, or caregivers
- but not recognized by the individual with dementia
Dementia – “When to Suspect”

**For example, the patient**
- is a “poor historian” or “seems odd,” reports same story within minutes
- is inattentive to appearance, inappropriately dressed, or dirty
- fails to appear for scheduled appointments or comes at the wrong time or wrong day
- defers to a caregiver; a family member answers questions directed to the patient
  - Spouse checking – “Head Turn Sign”

**Be a sleuth…**

**look for clues**
- Getting lost, accidents
- Repetitive
- Forgets conversations
- Misplaces objects
- Agitation and depressive sx.
- Functioning (ADL/IADL)
Dementia – “What to Do”

Think of other causes of cognitive impairment such as:

1. Delirium (especially due to medications, severe medical conditions such as sepsis or renal failure - this is common in hospitalized patients)
2. Depression
3. Other psychiatric disorders (schizophrenia, psychosis, delusions, bipolar disease)
4. B12 deficiency
5. Hypothyroidism
6. Metabolic upsets (electrolyte imbalances, renal failure, liver failure)
7. Infections (in the younger age group (<50) – HIV especially with any high risk behavior – substance abuse, STDs, gay or bisexual men, immigrant, unusual MRI that doesn’t fit typical pathology)
8. Neoplasm
9. Substance abuse induced conditions (alcohol especially)
Mini-Cog = 3 item recall and clock drawing
- 3-minute administration time
- Do immediate and delayed 3-word recall
- Clock in between

Sensitivity 76-99% and Specificity 89-93%
- strong predictive value, better than MMSE in mild dementia

If no mistakes, the probability of no dementia > 95%
Not for use in someone with no suspicion of cognitive impairment*

Abnormal results should be followed up with more comprehensive assessments – medical evaluation
- see previous “what to do slide” and
- testing like MoCA or SLUMS and/or possibly specialty consultation

Dementia – Confirmatory tests of impaired cognition

MoCA
- Montreal Cognitive Assessment – in KPHC

SLUMS
- St. Louis University Mental Status exam – in KPHC

<> Mini-Mental Status exam – copyrighted test, not in KPHC

These tests can validate and measure the degree of cognitive impairment but cannot by themselves establish a diagnosis of dementia.
SLUMS EXAMINATION

Questions about this assessment tool? E-mail aing@slu.edu

Is the patient alert? __________________ Level of education __________________

1. What day of the week is it?
2. What is the year?
3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.
   Apple  Pen  Tie  House  Car
5. You have $100 and you go to the store and buy a dozen apples for $5 and a tricycle for $20.
   How much did you spend?
6. How much do you have left?
7. Please name as many animals as you can in one minute.
   0 1 2 3 4 animals
8. What were the five objects I asked you to remember? 1 point for each one correct.
9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o’clock.
   Hour markers okay
   Time correct
10. Please place an X in the triangle.
11. Which of the above figures is largest?
12. I am going to tell you a story. Please listen carefully because afterwards, I am going to ask you some questions about it.
   Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
13. What was the female’s name?
14. When did she go back to work?
15. What state did she live in?

TOTAL SCORE

CLINICIAN’S SIGNATURE     DATE     TIME

Score
27-30………………normal
21-26…………mild impairment
1-20………………dementia

MOCA – Montreal Cognitive Assessment

**Score:**

26-30 ................. normal
Dementia – Standard work-up

**Laboratory tests**
- Electrolyte panel, including
  - Calcium *(especially with hx of previous CA)*
  - renal function
  - glucose
- Thyroid studies
- Vitamin B12
- CBC

**Optional**
- Methylmalonic acid
- RPR/Treponemal
- Radiology: Head CT or MRI for indications
Physical Exam

Assess cognitive function

Neurologic exam-signs of
- Cranial nerves
- gross motor/sensory losses
- cerebellar fxn

Vascular signs/risk factors

Gait and balance
- get-up and go/Tinetti
Assess Function

**ADL - 6 items, basic**
- Dressing
- Bathing
- Feeding
- Toileting
- Transfers
- Continence

**IADL - 9 items**
- Telephone- use alone
- Shopping alone/ok
- Meal preparation
- Laundry
- Light Housekeeping
- Takes meds correctly
- Manages Money
- Transportation
- “Handyman” work
Types of Dementia

**Alzheimer’s**
- Neurodegenerative 70-80%
- Gradual progression
- Starts with memory/language changes

**Vascular (and mixed)**
- Risk factors
  - stepwise progression
  - “significant” periventricular white matter disease
  - setting of vascular disease

**Frontotemporal Dementia**
- Disinhibition with alteration of personality

**Lewy Body**
- Movement and hallucinations present
- “Parkinsons dementia”
Mild Cognitive Impairment (MCI)

Cognitive impairment on formal testing
- beyond that expected for age

May be noticeable to others

Does not interfere significantly with daily activities

Approximately 10-15% of persons diagnosed with MCI will convert to a diagnosis of dementia each year
- as opposed to 1-2% per year in controls

Identify and retest yearly with Mini Cog
Clinical Progression of MCI and AD

Time (y)

MCI
- Mild subjective/objective memory loss
- Normal function

Mild AD
- Forgetfulness
- Repetitive questions
- Daily function impaired

Moderate AD
- Progression of cognitive deficits
- Short-term memory loss
- Word-finding difficulties

Severe AD
- Agitation
- Altered sleep patterns
- Total dependence: dressing, feeding, bath
Why diagnose dementia?

- Confirm diagnosis
- Explain natural history
- Counsel family
- Anticipate stages and needs
- Assess present capacity
- Treatment (?)
- End-of-life planning
- Refer to Social Service (?)
Social Issues

Alzheimer’s association recommends telling patient of diagnosis

Power of Attorney for Health Care
- Address early-get copy/document
- Address in non-threatening fashion

Caregiver stress
- Caregivers frequently feel pressure/stress- need to be aware
- Need to prevent caregiver burnout/elder abuse

Living situation
- Assess if adequate for current functional level-plan for future (with family if possible)

Adult Protective Services (APS)
- Report if dangerous home environment

Driving
- Report disability to Motor Vehicle Division -- May be state law!
Dementia with Complications - Behavioral Problems: Psychosis in Dementia

Delusions are common
- 40-50% of patients with Alzheimer’s disease

Visual and Auditory hallucinations may occur as well

Content is frequently persecutory (paranoid)
- Theft
- House is not home
- Caregiver will abandon or is an impostor
- Mate is unfaithful

Not all cause behavior problems but are still a complication

Impaired memory is easily mistaken for psychosis
(e.g. not all delusions are “psychotic”)
- Mother is waiting
- Need to go to work

Devanand et al. Geriatrics. 1997(Sep);52(suppl 2):S37-S39
Behavioral Problems: Agitation in Dementia

**Physical**
- Pacing
- Inappropriate robing/disrobing
- Trying to get to a different place
- Handling things inappropriately
- Restless
- Stereotype
- Hitting, kicking, scratching
- Tearing, biting, spitting

**Verbal**
- Complaining
- Requests for attention
- Negativism
- Repeated questions, phrases
- Screaming
- Accusing
- Name-calling
- Obscenities
An approach to managing “behaviors” in dementia

Behaviors → Problem
Restlessness → Pain
Calling out → Mood volatility
Combativeness → Thought disorder
Aggression → Hallucinations
Misperception → Depression
Impulsivity → Anxiety
Apathy → Insomnia
Disrobing → Disinhibition

Solutions?
Non-Drug
Redirecting
Re-orienting
Tasks
Daylight
Model desired behavior

Drug
Analgesics
Mood stabilizers
Antipsychotics
Antidepressants
Sedatives?
Cholinesterase inhibitors ???

“SEDIMENT” – What is causing the behavior problem? – a useful mnemonic

**S**ymptoms – any indication of something common causing symptoms (i.e. pain – constipation, bladder distention, joint swelling), fever, vomiting, etc.

**E**nvironment – any new changes in environment or routines, travel

**D**rugs – new medications, med interactions, accumulation or dosing problems

**I**nfection – urinary, respiratory or atypical presentation of an infection

**M**etabolic – electrolyte imbalance, renal failure

**E**xacerbation of Existing Condition – worsening Heart Failure, Depression, COPD

**N**ew Pathology – Pain causing agitation, anemia causing lethargy

**T**rauma – falls, head injury, accidents, neglect, or abuse
Psychiatric symptoms of dementia: Treatable, but no silver bullet

ABSTRACT

Behavioral problems are common in dementia and may reduce the quality of life of the patient and disrupt the home life of family members. Families want a pill that can cure the myriad phenotypes of a decaying brain; unfortunately, there is no pharmaceutical silver bullet. This paper reviews the evidence for using different classes of drugs for the behavior symptoms commonly encountered in dementia, focusing on concerns that the primary care physician would have about using these drugs.
Case:

You are called by the hospital ward nurse because Verda has pulled out her IV line and is repeatedly attempting to get out of bed without assistance and “cranky” and directing profane language at her nurse and bothering other patients.

Her daughter is upset, saying this is not at all like her mother, but acknowledging that the she began having trouble with her memory about six months ago and sometimes forgets that her husband Elmer died.

When you get to the bedside to evaluate Verda 30 minutes have passed, and she seems peaceful.

Diagnosis?
## Delirium vs. Dementia

Delirium can be a complication of dementia or the main diagnosis which mimics dementia

<table>
<thead>
<tr>
<th>Features</th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>Acute</td>
<td>Insidious</td>
</tr>
<tr>
<td><strong>Course</strong></td>
<td>Fluctuating</td>
<td>Progressive</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Days to weeks</td>
<td>Months to years</td>
</tr>
<tr>
<td><strong>Consciousness</strong></td>
<td>Altered</td>
<td>Clear</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
<td>Impaired</td>
<td>Normal, except in severe dementia</td>
</tr>
<tr>
<td><strong>Psychomotor changes</strong></td>
<td>Increased or decreased</td>
<td>Often normal</td>
</tr>
<tr>
<td><strong>Reversibility</strong></td>
<td>Usually</td>
<td>Rarely</td>
</tr>
</tbody>
</table>

Many disorders and drugs can cause delirium
No lab tests help make the diagnosis, but they can point to contributing factors
Promptly correcting the condition(s) causing delirium results in marked improvement
Delirium affects 15 to 50% of hospitalized people aged 70 or older.
Delirium is never normal and often indicates a usually serious, newly developed problem, especially in older people.
Mental status and behavior changes with delirium range from apathy to marked agitation
# Delirium Clinical Criteria

Criteria 1, 2 and 3 plus either 4 or 5 are required to confirm a diagnosis delirium*

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute change in mental status, AND</td>
<td>Observation by a family member, care giver, or primary care physician</td>
</tr>
<tr>
<td>2. Symptoms that fluctuate over minutes or hours, AND</td>
<td>Observation by nursing staff or caregiver</td>
</tr>
<tr>
<td>3. Inattention</td>
<td>Patient history</td>
</tr>
<tr>
<td></td>
<td>Poor digit recall, inability to recite months of year backwards</td>
</tr>
<tr>
<td><strong>PLUS</strong></td>
<td></td>
</tr>
<tr>
<td>4. Altered level of consciousness, OR</td>
<td>Hyperalertness, drowsiness, stupor or coma</td>
</tr>
<tr>
<td>5. Disorganized thinking</td>
<td>Rambling or incoherent speech</td>
</tr>
</tbody>
</table>

* Source: Inouye, S. Ann Int Med 1990; 133:941-948
Eleven additional features of Delirium

1. Correlates with patient age and underlying dementia
2. Natural history widely variable
3. Can be potentiated by pain meds, or by pain itself
4. Mild cases have to be diagnosed in relation to baseline
5. Family may detect before medical staff
6. Hallucinations occur more frequently than they are reported
7. Distinguishing delirium from dementia important for prognosis
8. Diagnosis is not always fully explained to family and patient
9. Opportunity to reassure patient should not be overlooked
10. Delirium is a hazard of hospitalization, especially of ICU
11. Delirium can be a normal feature of dying process
### Causes of delirium

<table>
<thead>
<tr>
<th>Fluid imbalance</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>Medications</td>
</tr>
<tr>
<td>Hepatic/Renal failure</td>
<td>Anticholinergics</td>
</tr>
<tr>
<td>Hypoxia</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Urinary retention</td>
<td>Opioids</td>
</tr>
<tr>
<td>Constipation</td>
<td>Steroids</td>
</tr>
</tbody>
</table>

- These conditions can be treated.
Management & Treatment of Delirium

Prevent it!
Ensure safety
Reverse
  by treating underlying cause
Relieve
  by re-orienting, relaxing, rehydrating (?), restoring normal environment

Inouye SK, et al. 2003 Arch Int Med 163:958
Pharmacotherapy for Delirium

- No FDA approved treatment
- No DB-RCTs
- Use 1st generation anti-psychotics
- Don’t use benzodiazepines unless treating alcohol or sedative withdrawal

For agitated delirium

- Haldol SC 1 mg q 30 minutes prn with call back to clinician if 3 doses not effective
  - More rapid onset than oral administration

- Black box warnings of increased mortality regarding anti-psychotics in dementia does not cover psychosis related to delirium
Dementia with Complications - Depression

Depression is a common co-morbidity with dementia
- 25-50%

PHQ2/9 is a recommended tool
- for screening and tracking older adults with depression
- can be used effectively in patients with mild cognitive impairment (MCI) and mild dementia

Geriatric Depression Scale (GDS)
- option for dementia patients
- given the yes/no format and
- lack of somatic questions

Depression diagnoses can be
- Mild
- Moderate
- Major

Often treatment of depression with careful monitoring can help
- in separating the depression components
- from the dementia impairments
<table>
<thead>
<tr>
<th>D</th>
<th>Depressed Mood (At Least One Of First 2 In Past 2 Wks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Loss Of Interest</td>
</tr>
<tr>
<td>G</td>
<td>Guilt Feeling</td>
</tr>
<tr>
<td>S</td>
<td>Sleep Disorder</td>
</tr>
<tr>
<td>P</td>
<td>Psychomotor Disturbance</td>
</tr>
<tr>
<td>S</td>
<td>Appetite Loss</td>
</tr>
<tr>
<td>C</td>
<td>Concentration</td>
</tr>
<tr>
<td>E</td>
<td>Lack Of Energy</td>
</tr>
<tr>
<td>S</td>
<td>Suicidal</td>
</tr>
</tbody>
</table>
### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:**

**DATE:**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(see “*” to indicate your answer)

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

**add columns:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

**TOTAL:**

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult
Yesavage
Geriatric
Depression Scale

## Depression Screen

Are you currently receiving (or have you during the past six months received) treatment for psychiatric or emotional problems? Yes/No

During the past four weeks, did you often feel sad or depressed? Yes/No

If positive on either, do Geriatric Depression Scale.

Geriatric Depression Scale: (short form)

Choose the best answer for how you felt over the past week.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you basically satisfied with your life?</td>
<td>Yes</td>
<td>NO</td>
</tr>
<tr>
<td>2. Have you dropped many of your activities and interests?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>3. Do you feel that your life is empty?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>4. Do you often get bored?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>5. Are you in good spirits most of the time?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>6. Are you afraid something bad is going to happen?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>7. Do you feel happy most of the time?</td>
<td>Yes</td>
<td>NO</td>
</tr>
<tr>
<td>8. Do you often feel helpless?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>9. Do you prefer to stay at home, rather than going out and doing new things?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>10. Do you feel you have more problems with memory than most?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>11. Do you think it is wonderful to be alive now?</td>
<td>Yes</td>
<td>NO</td>
</tr>
<tr>
<td>12. Do you feel pretty worthless the way you are now?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>13. Do you feel full of energy?</td>
<td>Yes</td>
<td>NO</td>
</tr>
<tr>
<td>14. Do you feel that your situation is hopeless?</td>
<td>YES</td>
<td>No</td>
</tr>
<tr>
<td>15. Do you think that most people are better off than you are?</td>
<td>YES</td>
<td>No</td>
</tr>
</tbody>
</table>

Bolded answers = 1 point.

**SCORE**

- Normal 3 +/- 2
- Mildly depressed 7 +/- 2
- Very Depressed 12 +/- 2
<table>
<thead>
<tr>
<th>Feature</th>
<th>PHQ</th>
<th>GDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
<td>Time</td>
<td>yes/no</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>Yes</td>
<td>Only 1 – fatigue</td>
</tr>
<tr>
<td>Number of Items</td>
<td>9 + 1</td>
<td>15</td>
</tr>
<tr>
<td>Symptom severity</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diagnosis based on DSM-IV</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Suicide or Self harm</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Function</td>
<td>Yes (Q 10)</td>
<td>No</td>
</tr>
</tbody>
</table>

Major Depression is diagnosed using DSM-IV criteria: 5 of the following 9 symptoms must be present for at least 2 weeks and one of these must be item 1 or 2

1. Depressed Mood
2. Loss of interest or pleasure
3. Significant change in weight or appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness, hopelessness, or guilt
8. Impaired concentration or ability to make decisions
9. Thoughts of suicide or self harm

PHQ9 covers these symptoms exactly
New Dementia HCCs

Two Dementia HCC Categories

Dementia Without Complication (HCC 52)
- Alzheimer’s
- Pick’s disease
- Dementia w/ Lewy bodies
- Vascular Dementia

Dementia With Complication (HCC 51)
- Dementia with behavior disturbance
  - aggression, violent
- Dementia with depression, delusion, delirium
Dementia is a chronic systemic condition

Minimum requirements to refresh dementia yearly

- Face-to-face encounter
- Document dementia and any related manifestations in the body of the progress note (HPI, ROS, Exam, Assessment/Plan)
- Report in the Encounter Diagnosis box in the Order Entry or
- Use the Chronic Disease Form

Per CMS and national coding guidelines

- “Systemic diseases…are always coded, even in the absence of documented active intervention.”
Summary

1. Dementia is common in older adults...and commonly unrecognized in its early phases. **Good reasons exist to make the diagnosis!**

2. Delirium is common in hospitalized older adults but distinct from dementia and also important to correctly diagnose and treat.

3. Depression is relatively common in older adults and commonly co-exists with dementia. It is also important to recognize and treat appropriately.