An Innovative Approach to Managing Behavioral and Psychological Dementia

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ABSTRACT

The older adult population in long-term care is experiencing significant growth, which includes an increased number of minority admissions. An estimated 48% of long-term care patients are admitted with a diagnosis of dementia. Patient-centered, culturally appropriate care is critical in the management of dementia and treatment of associated behavior and psychological symptoms of dementia (BPSD). The use of personalized music playlists has shown promise in the interdisciplinary treatment of BPSD. Regulatory agencies are closely monitoring the management of BPSD. Accurate diagnosis and treatment of BPSD is an increasingly important skill for the provider.

Keywords: BPSD, culturally appropriate, dementia, individualized music, interdisciplinary, older adult, regulatory

DEMENTIA AND THE OLDER ADULT

The older adult population has demonstrated significant growth over the last 2 decades. Minority populations have increased from 18% of the total population in 2004 to 22% in 2014. Projections predict minority populations will increase to 28% of the total population by 2030.[1] The United States Centers for Disease Control (CDC) reported that, in 2014, there were 1.4 million residents in long-term care facilities (LTCFs) in the US.[2] Research indicates numbers of racial and ethnic minority patients in long-term care are increasing even faster than the minority population overall.[3]

Alzheimer's disease and other forms of dementias are common diagnoses among patients in LTCFs. In the last quarter of 2016, in LTCFs, the Minimum Data Set (MDS) revealed a diagnosis of dementia at a prevalence of 42.87% in Medicare- and Medicaid-certified facilities.[4] The MDS is a federally mandated standardized process of assessing the clinical status of patients in Medicare- and Medicaid-certified LTCFs across the US and provides a listing of specific diagnoses among patients.

BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

Dementia has a significant impact on patients, families, and caregivers, and can affect quality of life. Patients with dementia may present with behavioral disturbances, which can impact the provision of care and place them at risk for injury. These behaviors have been termed as the behavioral and psychological symptoms of dementia (BPSD). Common to patients in long-term care with dementia, these behaviors can negatively affect quality of life for the patient and the ability of the staff to provide care. Symptoms may include agitation, aggression, psychosis, and other inappropriate behaviors.[5,6] Negative and inappropriate vocalizations and wandering are other behaviors that can put the patient with dementia at risk. Based on the MDS reports for the last quarter of 2016, at least 18.8% of patients in long-term care with dementia have behaviors that interfere with daily activities. These behaviors showed a prevalence of 22.5%. Behaviors that placed other residents at risk for physical injury were reported at 12.49% and behaviors placing the resident themselves at risk for physical injury at 12.44%.[4]

TREATMENT AND MANAGEMENT OF BPSD

The treatment and management of BPSD is multifold. Common practices include determining the underlying cause of the behavior, communication tools such as redirection, providing person-centered care, and the use of antipsychotic agents.[4,7,8] Potential underlying causes of unprovoked behavior include: infection; pain; medication effects or toxicity; fear; abuse; boredom; hunger; and/or thirst. Communication tools may include redirection or change in approach to the resident. Redirection is used as a first-line intervention to reduce or eliminate wandering or negative vocalizations.[9]

Studies have emphasized the importance of and improved outcomes with person-centered care for patients diagnosed with dementia in the long-term care setting. This system emphasizes that, despite cognitive impairment, patients can still maintain their identity. Recognizing, understanding, and acknowledging the feelings of a person with dementia through care actions is central to person-centered care. Identifying things that have meaning to the patient are essential in this approach. Studies have shown that person-centered care offers an evidence-based approach in which caregivers can incorporate patient preferences, feelings, culture, and life history into patient interactions.[9,10] Additional studies are warranted regarding interventions that support the benefits of developing culturally sensitive, person-centered dementia care. With increases in the overall and minority older adult population overall and minority long-term care admissions, appropriate person-centered, culturally based care becomes important in those with dementia.[8,11,12]

Antipsychotic medication use in dementia is not supported in the evidence-based literature and is not considered best practice. The Beers Criteria is an evidence-based list developed to help providers improve medication safety while prescribing for older adults. This list incorporates pharmacologic properties and the physiologic changes that occur with aging, which can render certain medications inappropriate in the older adult. Antipsychotics are listed as a potentially inappropriate medication choice in older adults, with strong evidence to support the potential for adverse outcomes.[13]

The prescribing of antipsychotics is not approved by the US Food and Drug Administration (FDA) in patients with dementia due to numerous side effects and increased mortality. A black box warning was issued in 2005 by the FDA related to increased mortality risk. Studies revealed the mortality rate in patients taking an antipsychotic was 4.5%, compared with 2.6% in the placebo group.[14–17] Best practices include management of BPSD with nonpharmacologic interventions, such as communication, redirection, finding underlying causes of behavior, and provision of person-centered care. Within the management tools of communication and person-centered care, the roles associated with cultural background become important in promoting quality of life for the increasingly diversified population of long-term care patients.[11,12]

ECONOMIC IMPACT

The economic impact for treating dementia and BPSD is growing and expected to continue to increase. By 2050, the projected expenditures for Alzheimer's and other dementia care will reach $1.1 trillion.[19] In 2011, Medicare Part D spending on antipsychotic drugs totaled $7.6 billion, which was the second highest class of drugs, accounting for 8.4% of Part D spending.[18] Individual atypical antipsychotics average in price from $100 to $600 per month.[20]

TREATMENT INNOVATION FOR BPSD

Evidence points to the benefits of music interventions in improving outcomes in agitation and other symptoms of BPSD. Even in advanced Alzheimer's disease (AD), some musical memories may be maintained. Cuddy and colleagues[21] proposed that the close links to emotion evoked by music allows for access to lifetime events. Music is thought to promote a physiologic response that can evoke autobiographical memories.[22-27] Music is diverse, encompassing a variety of cultural preferences and can be an effective component of person-centered care. Developing a personalized music list, which has meaning to the individual patient, may tap into these autobiographical memories. Invoking positive memories through personalized music is increasingly demonstrating positive patient outcomes, including